FAIRFAX COUNTY GOVERNMENT

Employee Benefit Plans

January 1, 2004 through December 31, 2004

BENEFIT SUMMARY HANDBOOK

Links for more information about your plan

BluePreferred PPO To see if your doctor is in the network http://www.bcbs.com/healthtravel/finder.html To see the cost of your prescription http://notesnet.carefirst.com/formulary/formulary.nsf To order a renewal prescription https://www.advancerx.com/sadvpcsrx_MyRx/index.jsp To see a list of eyecare providers http://carefirst.benefitnation.net/pcp_finder.asp?Type=SPC&plan=CF To see information on alternative therapies http://www.carefirst.com/pages/options/options.main.htm To contact customer service http://www.carefirst.com	**FairChoice+BlueChoice** To see if your doctor is in the network http://carefirst.benefitnation.net/bc_router.asp To see the cost of your prescription http://notesnet.carefirst.com/formulary/formulary.nsf To order a renewal prescription https://www.advancerx.com/sadvpcsrx_MyRx/index.jsp To see a list of dentists http://carefirst.benefitnation.net/pcp_finder.asp?Type=BPD&Plan=XX To see a list of eyecare providers http://carefirst.benefitnation.net/pcp_finder.asp?Type=SPC&plan=CF To see a list of mental health providers http://carefirst.benefitnation.net/bluechoiceMentalRouter.asp?Type=MEN&plan=CF To see information on alternative therapies http://www.carefirst.com/pages/options/options.main.htm To contact customer service http://www.carefirst.com
Kaiser Permanente To select a doctor http://www.kaiserpermanente.org/locations/midatlantic/index.html To see if a particular drug is in the formulary http://www.kaiserpermanente.org/locations/midatlantic/members/formulary1.html To order a renewal prescription http://www.kaiserpermanente.org/locations/midatlantic/members/rxrefill.html To get answers to your health questions, http://www.kponline.org To download a copy of the Signature Plan Member Guide http://www.kaiserpermanente.org/locations/midatlantic/members/signature.pdf To see a list of dentists through Kaiser's contracted dental plan http://www.dbp-inc.com/site_build/member/member_services.asp To make a medical appointment http://www.kponline.org To contact customer service http://www.kaiserpermanente.org/locations/midatlantic/members/membersvsonline.html	**CIGNA** To select a doctor http://CIGNA.benefitnation.net/CIGNA/docdir.html To see the cost of your prescription http://www.CIGNA.com/consumer/services/pharmacy/three_tier.html For information on the mail-order prescription service http://www.CIGNA.com/consumer/services/pharmacy/tel_drug.html For information on the CIGNA dental plan http://www.CIGNA.com/consumer/services/dental/care.html To select a dentists on the CIGNA dental plan http://CIGNA.benefitnation.net/CIGNA/docdir.html For information on the CIGNA Healthy Rewards program http://CIGNA.com/consumer/services/healthcare/programs/rewards.html

Dental Benefit Providers of Maryland (DBP) To select a dentist http://www.dbp-inc.com/site_build/MapApp/member/Criteria.asp To see the cost of a dental procedure http://www.dbp-inc.com/site_build/member/memberfee.asp To contact customer service http://www.dbp-inc.com/site_build/member/member_services.asp	**Dominion Dental (DHMO)** To select a dentist http://www.dominiondental.com/provider/psearch.html **Dominion Dental (DPPO)** To select a dentist http://www.dominiondental.com/provider/psearch.html
Deferred Compensation ICMA http://www2.icmarc.org/xp/vl/ TRowe Price http://www.troweprice.com VALIC http://americangeneral.com/fairfaxcounty	**Flexible Spending Account** To access your account http://www.ceridianfsa.com To determine your tax savings http://www.ceridianfsa.com/products/fsa/sponsor/fsacalc_indiv.shtml
Long-Term Care Insurance For information about the plan http://www.aetna.com/group/fairfaxcounty	**Virginia College Tuition Savings Plans** Virginia Prepaid Education Program http://www.virginia529.com Virginia Education Savings Trust http:/www.virginia529.com College America http://www.americanfunds.com

Fairfax County government employees enjoy a comprehensive benefits package during their career and after retirement.

In this benefits handbook we provide information on those benefits administered by the Employee Benefits Division of the Department of Human Resources, which include health and dental insurance, deferred compensation, flexible spending accounts, term life insurance, universal life insurance, long-term disability salary insurance, long-term care insurance and the Virginia College Savings Plans. Also, we provide information on retiree health, dental and life insurance benefits.

Your County benefits increase the value of your compensation by close to 25%.

The *Fairfax County Government Employee Handbook*, also available from the Department of Human Resources, covers all other benefits programs, including leave polices, child care services, the Employee Assistance Program, holidays, employee fitness, and pay rates.

Retirement plan benefits for general County employees are outlined in the *Fairfax County Employees' Retirement System* booklet, which is available at the Government Center in the Department of Human Resources, Suite 258, in Fairfax City at the Retirement Agency office at 10680 Main Street, Suite 280, and on the Infoweb.

Every other week the Department of Human Resources provides updated information on your benefits during a new employee orientation. Current employees are welcome to attend to learn more about available benefits. Check the Human Resources site on the Infoweb for a schedule of orientation meetings.

Do you have a human resources question?
E-Mail your question to mailto:HRExpress@fairfaxcounty.gov.

The Human Resources website on the Infoweb provides information on all benefits offered through the County that are included in this booklet. There are direct links to the various vendors and enrollment forms can be downloaded.

We are happy you have decided to make a career at Fairfax County and we are here to help you make the best decisions on your benefits for now and in the future. Come see us anytime.

Peter J. Schroth
Director, Department of Human Resources

What you will find in this booklet

New employees

New employees have 60 calendar days to join one of the County's health and/or dental plans.

Current employees

Current employees can make changes to their benefits during open enrollment or within 60 days of a qualifying event.

Open enrollment

is Oct. 1-31, 2003, for employees and retirees. All open enrollment changes are effective Jan. 1, 2004.

If you are a new employee of Fairfax County government or a current employee with benefit questions, this booklet will help you understand and make decisions on County benefits available to you and your family. It provides information on the County's health and dental care coverage, deferred compensation program, flexible spending account programs, the Virginia College Savings Plan, life insurance, disability insurance, and long-term care insurance.

In you are a new employee, you will have 60 calendar days to join one of the County's health or dental plans. All benefits have deadlines for enrollment so see individual sections in this booklet for specific plan deadlines.

If you are a current employee, during the annual open enrollment period, you are eligible to make changes to your health and dental plans, add or drop dependents, cancel your plan, enroll in flexible spending accounts for the next year, or request to increase or decrease your group term life insurance coverage and/or dependent coverage. The open enrollment period this year will be Oct. 1-31, 2003, with changes effective Jan. 1, 2004.

If you are a current retiree, during the annual open enrollment period you are eligible to make changes to your health and dental plans and add dependents to your plans. Remember, retirees can cancel coverage any time during the year, but once coverage is cancelled by the retiree, it is not possible to reenroll in a County plan in the future. Open enrollment for retirees is also Oct. 1-31, 2003.

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Fairfax County is committed to nondiscrimination on the basis of disability in all County programs, services, and activities. Special accommodations will be provided upon request. For information call (703) 324-4917 (voice) or (703) 222-7314 (TTY) or (703) 802-8795 (FAX).

Special thanks to employees Trevor Olson, Don Sweeney and Scott Boatright for contributing their photos for the cover.

Your health and dental benefits

Fairfax County offers its employees and retirees a variety of health and dental plans.

Health plans for 2004 include: FairChoice+BlueChoice, BluePreferred PPO, Kaiser Permanente, and CIGNA HMO HealthCare. There are three dental plans: Dental Benefit Providers DHMO, Dominion Dental DHMO and Dominion Dental PPO.

If you are currently enrolled in FairChoice+BlueChoice, BluePreferred PPO, Kaiser Permanente, or CIGNA and/or any of the dental plans and choose to continue the coverage, you do **not** have to submit a form during open enrollment**.** If you would like to be in a plan other than your current plan, you will need to submit an enrollment form to the Benefits Division in Suite 258, Government Center (FAX (703) 802-8795), during open enrollment. Changes will be effective Jan. 1, 2004.

Health plans

This section and the next contain general information about the health care plans and summarize the major features of each of the health plans offered by the County. Plan details are not covered in this summary. **Refer to the benefit booklet for the individual plan for specific information on plan benefits.**

You may enroll in one of the following health insurance plans:

- **FairChoice+BlueChoice:** A point-of-service plan (POS) combining the best features of a health maintenance organization (HMO) and a traditional indemnity plan. Employees have access to the BlueChoice network. BlueChoice covers Northern Virginia, Maryland and Washington, D.C.

- **BluePreferred PPO:** A preferred provider plan combining an in-network benefit and an out-of-network benefit. For the in-network benefit there is a network of doctors and other health providers, including hospitals, that have agreed to discount their usual fees for plan members. When you use a provider in the network, the charges to the health insurance plan are lower, giving you the highest level of benefits.

- **Kaiser Permanente:** A group model HMO**.** Staff doctors and nurses are located at a medical center. You go to that facility for your appointments. Specialists may be located at the facility or at their own offices elsewhere.

- **CIGNA:** An Independent Practice Association (IPA) HMO**.** Doctors have their own offices and you go to the office of your primary care physician for treatment. Your doctor may be a member of several health insurance plans.

Notes:
See the 2004 changes to the health plans at the top of this page.

The Health Care Benefits at-a-glance chart summarizing the covered services under each plan is on pages 5-7. It provides general information only.

Changes to the Plans for this year include:

FairChoice+BlueChoice and BluePreferred PPO

New prescription co-payments

- Up to a 30-day supply at local pharmacy:
  - $10 generic
  - $20 preferred brand name
  - $35 non-preferred brand name
- Up to a 90-day supply by mail
  - $20 generic
  - $40 preferred brand name
  - $70 non-preferred brand name

Kaiser Permanente

New prescription co-payments

- Kaiser center:
  - $10 generic
  - $20 brand name
- Community pharmacy
  - $16 generic
  - $32 brand name
- Mail order
  - $8 generic
  - $18 brand name

CIGNA

Home Health Care – 60 day calendar year maximum benefit

Refer to the individual plan booklet for plan specific benefit information. If there is a conflict between the eligibility rules in a health plan booklet and in this booklet, the County's rules in this booklet will apply.

It is a good idea to attend one of the County's employee meetings during open enrollment. Both the Employee Benefits Division and the individual plans will have representatives at these meetings to answer your questions.

Features of the FairChoice+BlueChoice and BluePreferred PPO plans

Flexibility

The FairChoice+BlueChoice plan and the BluePreferred PPO plan are designed to meet the needs of Fairfax County Government employees. The FairChoice+ BlueChoice point-of-service plan offers you flexibility because each time you need care you can choose the option you want to use. The BluePreferred PPO plan offers you flexibility because you don't need to get referrals, you don't need to select a primary care physician (PCP), and it has a much larger nationwide network.

Self-insured

The FairChoice+BlueChoice and the BluePreferred PPO plans are self-insured by the County. This means that your biweekly payroll health insurance deductions and the County's share of the premium are deposited into a trust fund set up by the County. Any interest accumulated in the trust fund is not paid to an insurance company, but is returned to the trust fund to reduce premium costs.

With a self-insured plan, the County, not a health plan, actually pays the cost of your health care claims. CareFirst will process claims from hospitals, doctors, and other health care providers. The County is then billed for these paid claims and must reimburse the health plans for these costs. The healthier participants are, the fewer claims the County must pay. This helps control the cost of health insurance for both plan members and the County.

Duplicate Billing/Overpayment Award Program

This program is designed to encourage employees to review their medical bills paid by the health plans. FairChoice+BlueChoice or BluePreferred PPO subscribers who detect errors of more than $50 in their medical bills or their dependents' medical bills will receive a financial reward of half the amount saved, up to $1,000. The remaining savings will be returned to the trust fund and used to pay other claims. For more information, contact the Employee Benefits Division of the Department of Human Resources at (703) 324-4917.

Things to consider when choosing a health plan

1. Do you need County health insurance?
If you have no other health insurance the answer almost certainly is YES. But if you are now covered by your spouse's plan, have a Medigap supplement, or are covered under a federal plan or another retiree plan, then you may not need a second plan. You do not want to pay for two plans that offer duplicate benefits, but make a well-informed decision before dropping any plan you have now. You may not be able to reinstate your coverage at a later time.

2. Consider your overall health, frequency of illness, and any special needs you or your family may have.
Are you looking for insurance just to cover an unexpected accident or major illness, or do you have a recurring need for treatment? Be sure the plan you select will cover any special condition that is of concern to you. Many plans have exclusions. There may be other restrictions. Read the plan literature carefully and call the Member Services Department of the health plan if you have unanswered questions.

3. Is it convenient?
Do you want to avoid filling out claim forms and paying some costs in advance of reimbursement? If you choose an HMO, how convenient is its closest center or participating doctor's office to your home or office? Are the appointment hours convenient? Which hospitals participate in the plan?

4. How much will it cost?
Be sure to look at both the biweekly premium deduction from your paycheck and out-of-pocket expenses, such as co-payments and deductibles.

5. Does it cover newborn costs?
If you are enrolled in an HMO plan and your spouse is covered under another HMO plan, you should review the rules regarding coverage for a healthy newborn baby. **Some plans do not cover any services related to the baby's birth when the mother is not covered in the HMO plan**.

Who to contact

Before choosing a health plan, read the material carefully to make sure it will meet your particular needs.

FairChoice+BlueChoice
(800) 441-1164
www.carefirst.com

County Benefits
(703) 324-3318

BluePreferred PPO
(800) 441-1164
www.bcbs.com

County Benefits
(703) 324-3318

CareFirst Help Desk
Betsi Fuhrman
(703) 324-3474

Kaiser Permanente
(301) 468-6000
www.kaiserpermanente.org

County Benefits
(703) 324-4708

CIGNA
(800) 244-6224
www.cigna.com

County Benefits
(703) 324-4708

Fairfax County Government
Health Insurance Premiums for Employees
January 1, 2004 - December 31, 2004

	Total Premium Cost	County Share	Employee Monthly Share	Employee Biweekly Share
FairChoice+BlueChoice				
Individual	$ 386.63	$329.13	$ 57.50	$ 28.75
2 Party	$ 759.79	$569.79	$190.00	$ 95.00
Family	$1,117.41	$838.41	$279.00	$139.50
BluePreferred PPO				
Individual	$ 444.61	$377.61	$ 67.00	$ 33.50
2 Party	$ 873.76	$655.76	$218.00	$109.00
Family	$1,285.03	$964.03	$321.00	$160.50
Kaiser				
Individual	$ 275.10	$234.10	$ 41.00	$ 20.50
2 Party	$ 536.43	$402.43	$134.00	$ 67.00
Family	$ 797.77	$598.77	$199.00	$ 99.50
CIGNA				
Individual	$ 305.23	$260.23	$ 45.00	$ 22.50
2 Party	$ 592.95	$444.95	$148.00	$ 74.00
Family	$ 886.30	$664.30	$222.00	$111.00

HEALTH CARE BENEFITS AT-A-GLANCE

FAIRCHOICE+BLUECHOICE		
	In-Network	**Out-of-Network**
Annual Deductible	None	$250 per person (with family coverage, only two family members must meet the deductible).
Yearly Out-of-Pocket Limit	None	$2,500 per person (does not include deductible). Two family members must meet out-of-pocket limit.
Lifetime Maximum Benefits	None	$1,000,000 per person in covered major medical benefits.**
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.* Physical exams limited to one per calendar year.
Inpatient Hospital Care	Covered in full.	Covered at 70% of plan allowance after deductible.*
In Hospital Doctors' Services	Covered in full.	Covered at 70% of plan allowance after deductible.*
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**	Covered at 70% of plan allowance after deductible* for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**
Maternity Care	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.*
Well Baby Care	Covered in full after $10 co-pay.	Unlimited well child visits to age 18, including immunizations, are covered at 70% of plan allowance not subject to deductible.*
Mental Health Services	**Inpatient –** Covered in full for up to 30 days per calendar year;* 90 day lifetime maximum. (Physician covered in full after $25 co-pay for one visit per day up to 30 days per calendar year.) **Outpatient –** Covered in full after $25 per visit co-pay, up to 20 visits per calendar year. *Limit is shared between mental health and substance abuse.	**Inpatient –** covered at 70% of plan allowance after deductible,* up to 20 days per calendar year for covered participants age 23 or older (25 days per calendar year for covered participants under 23). **Outpatient –** visits 1-5 per calendar year: covered at 70% of plan allowance after deductible,* thereafter 50% of plan allowance after deductible for unlimited number of visits.
Alcohol and Drug Abuse Treatment	Same as mental health.	Same as mental health.
Prescription Drugs	*Retail* (up to 34 day supply): $10 – co-pay for generic drugs $20 – co-pay for formulary brand name drugs $35 – co-pay for non-formulary brand name drugs. *Mail order* (up to 90 day supply): $20 – co-pay for generic drugs $40 – co-pay for formulary brand name drugs $70 – co-pay for non-formulary brand name drugs.	Same as In-Network.
Laboratory & X-ray	Covered in full at approved radiology and laboratory centers, $25 co-pay at approved outpatient department of hospital.	Covered at 70% of plan allowance after deductible.*
Vision Care	Eye exams covered in full after $10 co-pay at participating vision care centers, $25 co-pay at participating ophthalmologist's office with a referral; eyeware discount.	Routine care not covered. Eyeglasses and contact lenses are covered at 70% of plan allowance after deductible* if required as a result of accidental eye injury, eye surgery, or eye disease.
Dental Care	Discounts on services provided by participating dentists.	Routine care not covered.
Physical Therapy	Covered in full after $10 co-pay, up to 90 days per condition per calendar year.	Covered at 70% of plan allowance after deductible.*
Emergency Treatment	Covered in full after $50 co-pay for a bona fide accidental injury or medical emergency. (Waived if admitted.) Otherwise benefit will be provided out-of-network.	Benefits provided in-network for a bona fide accidental injury or medical emergency. Otherwise, covered at 70% of plan allowance after deductible.*

* After maximum out-of-pocket amount is reached, plan pays at 100% of plan allowance. **FairChoice+BlueChoice and BluePreferred PPO combined.

HEALTH CARE BENEFITS AT-A-GLANCE

BLUEPREFERRED PPO		
	In-Network	**Out-of-Network**
Annual Deductible	None	$250 per person (with family coverage, only two family members must meet the deductible).
Yearly Out-of-Pocket Limit	$1,000 per person (does not include deductible or co-payments). Two family members must meet out-of-pocket limit.	$2,500 per person (does not include deductible). Two family members must meet out-of-pocket limit.
Lifetime Maximum Benefits	None	$1,000,000 per person in covered major medical benefits.**
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.* Physical exams limited to one per calendar year.
Inpatient Hospital Care	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Inpatient Physician Billed Services	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime covered at 90% of plan allowance.* $100,000 lifetime maximum.**	Covered at 70% of plan allowance after deductible* for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**
Maternity Care	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Well Baby Care	Covered in full after $10 co-pay.	Unlimited well child visits to age 18, including immunizations, are covered at 70% of plan allowance not subject to deductible.*
Mental Health Services	**Inpatient –** Covered at 90% of plan allowance* up to 30 days per calendar year;** 90 day lifetime maximum**. Physician billed services –** 90% of plan allowance.* **Outpatient –** Covered at 90% of plan allowance,* up to 20 visits per calendar year. **Limit is shared between mental health and substance abuse.	**Inpatient –** covered at 70% of plan allowance after deductible,* up to 20 days per calendar year for covered participants age 23 or older (25 days per calendar year for covered participants under 23). **Outpatient –** visits 1-5 per calendar year: covered at 70% of plan allowance after deductible,* thereafter 50% of plan allowance after deductible* for unlimited number of visits.
Alcohol and Drug Abuse Treatment	Same as mental health.	Same as mental health.
Prescription Drugs	*Retail* (up to 34 day supply): $10 – co-pay for generic drugs $20 – co-pay for formulary brand name drugs $35 – co-pay for non-formulary brand name drugs. *Mail order* (up to 90 day supply): $20 – co-pay for generic drugs $40 – co-pay for formulary brand name drugs $70 – co-pay for non-formulary brand name drugs.	Same as In-Network.
Laboratory & X-ray	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Vision Care	Eye exams covered in full after $10 co-pay at participating vision care centers, eyeware discounts.	Routine care not covered. Eyeglasses and contact lenses are covered at 70% of plan allowance after deductible* if required as a result of accidental eye injury, eye surgery, or eye disease.
Dental Care	N/A	N/A
Physical Therapy	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Emergency Treatment	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*

* After maximum out-of-pocket amount is reached, plan pays at 100% of plan allowance. **FairChoice+BlueChoice and BluePreferred PPO combined.

HEALTH CARE BENEFITS AT-A-GLANCE

	KAISER	CIGNA
Annual Deductible	None	None
Yearly Out-of-Pocket Limit	N/A	$1,000 individual co-pay. $2,000 family co-pay.
Lifetime Maximum Benefits	None	None
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay; $0 co-pay for children up to 5 years of age.	Covered in full after $10 co-pay per visit.
Inpatient Hospital Care	Covered in full.	Covered in full.
In Hospital Doctors' Services	Covered in full.	Covered in full.
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime; covered at 50% of allowable charges.	Cover office visits, diagnosis and medical/surgical treatment **excluding** drugs, in-vitro, GIFT, ZIFT, etc. $10 co-pay; plus 50% coinsurance applies to physician's charges for treatment/surgical procedures.
Maternity Care	Covered in full after a $10 co-pay on the first prenatal visit.	Covered in full after a $10 co-pay on the first pre-natal visit.
Well Baby Care	Covered in full; $0 co-pay up to 5 years of age; $10 co-pay per visit thereafter.	Covered in full after $10 co-pay per visit.
Mental Health Services	**Inpatient –** Covered in full when medically necessary. **Outpatient -** $10 co-pay per visit when medically necessary.	**Inpatient –** Covered in full when medically necessary. **Outpatient –** Visits 1-5: $10 co-pay per visit. Visits 6-30: $20 co-pay per visit. Visits 31+; $25 co-pay per visit. **Group –** Visits 1-5: $10 co-pay per visit.Visits 6+: $20 co-pay per visit.
Alcohol and Drug Abuse Treatment	Same as mental health.	Same as mental health.
Prescription Drugs	Covered in full after $10 generic or $20 brand name co-pay at Kaiser Pharmacy; $16 generic or $32 brand name co-pay at community pharmacy; and $8 generic or $18 brand name co-pay for mail order. Ovulation and anorexiant drugs covered in full after co-pay of 50% average wholesale price (AWP). Viagra offered at 100% of the AWP only. Smoking cessation products will be prescribed to members who are in a formal smoking cessation program and shall be charged at 50% of the AWP.	Covered in full after $5 co-pay for generic drugs, $15 co-pay for preferred brand drugs and $35 co-pay for non-preferred brand drugs. Mail order - $15 co-pay generic; $45 co-pay preferred brand name; $105 co-pay non-preferred brand.
Laboratory & X-ray	Covered in full.	Covered in full.
Vision Care	Covered in full after $10 co-pay for optometry (eye refraction exam only) and ophthalmology visits; 25% eyeware discount; 15% initial fitting and contact lens discount.	$10 co-pay for eye exams every 24 months at a participating provider. Dollar allowances provided toward purchase of materials and hardware.
Dental Care	Discounts on services.	DHMO – based on a patient charge schedule of pre-set fees for each covered service at a participating provider.
Physical Therapy	Short-term therapy covered in full after $10 co-pay per visit. 90 day limit per incident per contract year.	Covered in full after $20 co-pay per visit. Maximum benefit of 60 visits per contract year.
Emergency Treatment	Covered in full after $50 co-pay per visit. Waived if admitted.	Covered in full after $50 co-pay per visit for emergency room; $25 co-pay per visit for urgent care facility. Waived if admitted

Dental plans

Employees may choose to enroll in one of three separate dental insurance plans: Dental Benefit Providers DHMO (Dental Health Maintenance Organization), Dominion Dental DHMO and Dominion Dental PPO (Preferred Provider Organization). All three plans place an emphasis on promoting healthy teeth and gums through preventive care and provide comprehensive coverage at a reasonable cost.

Three dental plans to choose from:

2 DHMOs: In-network benefits only – lower out-of-pocket costs.

1 Dental PPO: In-network and out-of-network benefits.

DHMO plans

The two DHMO plans require you to receive services from a participating plan dentist. Each family member enrolled in the plan must choose his/her own primary care dentist from a list of plan providers. The designated dentist will be the dental care manager for all services related to your family member's dental care. Generally, the DHMO plans provide higher benefits and lower out-of-pocket costs than the PPO plan.

DHMO members are not required to pay a co-payment for preventive, diagnostic or basic dental services. There is, however, a $5-$10 sterilization fee per visit. Other covered services are provided at a scheduled co-payment amount. Co-payment amounts for other services are listed in each plan's brochure.

As a DHMO member, you may change your primary care dentist at any time. The change becomes effective the first of the month following the request. The request must typically be made by the 20th of the month.

PPO plan

The Dominion Dental PPO Plan is a dual option plan that allows you to receive both in-network and out-of-network benefits. If you see a preferred provider listed in the PPO provider directory, you will qualify for in-network benefits. If you choose a dentist not reflected in the PPO directory, your claims will be processed under the out-of-network option. Benefits for the in-network option are generally higher than out-of-network benefits.

Comparison of plans

The Comparison of Employee Out-of-Pocket Costs and Plan Design Chart on page 10 will help you compare key features of the two DHMO plans. The chart is only a general summary of benefits so it is important to review each plan's brochure for detailed information as well as the participating providers list.

Effective date

For new hires, coverage will be effective the first of the calendar month following receipt of the enrollment form in the Employee Benefits Division in the Department of Human Resources. For qualifying events, see pages 32-34.

Exclusions and limitations

See plan brochures for a complete list of exclusions and limitations. Under HIPAA, the exclusion period must be reduced by the total period of prior creditable coverage. For more information on HIPAA, see page 20.

Claims filing

There are no claim forms to file under a DHMO plan. Claim forms for the PPO plan should be mailed to Dominion Dental Services Inc., 111 Ryan Court, Suite 300, Pittsburgh, PA 15205-1324**.** Dentists may use the standard American Dental Association approved dental claim form, or PPO members may request forms directly from Dominion by calling (888) 518-5338. To check on the status of a claim for the PPO plan, a member may call (888) 391-3374.

It should be noted that the PPO plan requires all dentists to obtain pre-approval for the following services: inlays, crowns, space maintainers, apicoectomy, oral surgery, periodontics, or cases where there is optional treatment with various fees. Your treatment plan will be submitted to the dental plan by your PPO dentist.

Coordination of benefits

The DHMO plans do not coordinate benefits with other dental plans. The PPO plan does allow coordination of benefits. Various factors determine the level of reimbursement including a determination of which plan is primary and which plan is secondary, and whether an in-network dentist is used.

Premiums

The County does not contribute toward dental premiums. Premiums are deducted pre-tax, biweekly, in the month of coverage. The biweekly payroll deductions for the period January 1, 2004 through December 31, 2004 are noted below by plan and coverage level:

Plan Type	Plan and Coverage Level	Biweekly Deduction
DHMO	**Dental Benefit Providers**	
	Individual	$ 9.21
	2 Party	$15.65
	Family	$21.69
DHMO	**Dominion Dental Services**	
	Individual	$ 7.78
	2 Party	$13.31
	Family	$18.87
PPO	**Dominion Dental Services**	
	Individual	$20.64
	2 Party	$35.29
	Family	$48.71

Who to contact

Dental Benefit Providers (DHMO)
(800) 445-9090
www.dbp.com

County Benefits
(703) 324-4708

Dominion Dental Services (DHMO & PPO)
(888) 518-5338
www.dominiondental.com

County Benefits
(703) 324-3318

DENTAL PLAN
Comparison of Employee Out-of-Pocket Costs and Plan Designs

	Dental Benefit Providers (DHMO)	Dominion Dental Services (DHMO)
X-rays	$0	$0
Teeth Cleanings	$0	$0
Sealants (molar teeth, up to age 17)	$0	$8
Topical Fluoride	$0	$0
Fillings (silver)	$0	$0
Fillings (comp.)	$0	$15 to $51
Oral Surgery	$15 to $105	$31 to $79
Root Canals	$106 to $208	$156 to $297
Periodontics		
Surgery	$83 to $182	$127 to $259
Repair and Maint.	$22 to $39	$35 to $55
Crowns		
Base Metal	$189 to $207	$297-$336
Hi Noble Metal	$220 to $236	$297^
Bridges		
Base Metal	$193 to $198	$297
Hi Noble Metal	$215 to $220	$297^
Dentures (each)	$238 to $278	$385 to $406
Orthodontics		
Children	$1,925#	$3,400#
Adults	$2,300#	$3,700#
Deductibles	$0	$0
Sterilization Charges	$5	$10
Maximum Annual Benefit	Unlimited	Unlimited
Maximum Lifetime Ortho. Benefit	Unlimited	Unlimited
Claim Forms	None	None

Dominion Dental Services (PPO)		
	In-Network	Out-of-Network
Deductible	$0	$50*
Preventative/ Diagnostic	100%**	90%**
Basic Care	80%**	70%**
Major Restorative Care	50%**	40%**
Orthodonture	50%**	40%**
Annual Maximum	$1,500*	$1,000*

* Per person/per year
** of Usual, Customary and Reasonable fee

\# Includes records and study models and one year retention.

^ An additional metals charge will be incurred ($18-$75).

NOTE: This is only a general summary. For detailed information, see each plan's fee schedule for covered benefits.

How to enroll in a health or dental plan

- Newly eligible employees have 60 calendar days from the qualifying event (see deadline chart on pages 61-64) to enroll.
- Current employees electing to make benefit changes during open enrollment have until close of business Oct. 31, 2003.
- Review the benefits offered by each plan.
- Determine which plan best meets your needs.
- Complete the plan's enrollment form. Include the following:
    - Level of coverage (individual, 2 party, family).
    - Primary care physician for every family member, if applicable. (primary care dentist also for CIGNA).
    - Social Security number and date of birth for every family member.
    - Address section of the enrollment form must be completed in order to distribute ID cards accurately and efficiently.
- If you are requesting coverage for your spouse, attach a copy of your marriage certificate or last year's income tax form showing that you are married.
- If adding a dependent with a different last name, attach a completed dependent certification form.
- Return the completed health/dental enrollment form(s) and any required documentation to the Employee Benefits Division of the Department of Human Resources by the designated deadline. It is not your agency's responsibility. If you miss the deadline, you must wait until the next open enrollment period unless you have one of the qualifying changes in status events. See page 32.
- If requested documentation is not received by the deadline specified, enrollment will be completed for those family members whose documentation is complete. Other changes must wait until the next open enrollment period.
- If you complete the enrollment form for a health or dental plan, you are authorizing the County to take pre-tax deductions from your pay for the biweekly premium amount.
- If you are canceling health insurance coverage during open enrollment, and you are not enrolling in a new plan, complete a Cancellation Only Request Form. The form can also be used to cancel dental, group term life insurance (optional and/or dependent coverage), universal life, and long-term disability. Long-term care insurance cancellations are made directly with Aetna insurance Co.
- All forms are available from your payroll contact or may be downloaded from the County's Infoweb.

Things to note

✓Form(s) and any required documentation must be sent to the Employee Benefits Division of the Department of Human Resources by the designated deadline.

✓Forms submitted to your agency do not meet the submission requirements until the forms are received in DHR.

✓If you miss the deadline, you must wait until the next open enrollment period unless you have one of the qualifying changes in status events. See page 32.

Q&A: health and dental plans

Q: Who is eligible for health and dental benefits?

All merit system employees of Fairfax County government (full and part-time), and employees from other approved participating political subdivisions for which the Department of Human Resources administers benefits, are eligible. Exempt part-time (less than 20-hour non-merit) employees and exempt limited term employees are not eligible. To find out if you are eligible, ask your agency personnel or payroll contact.

Q: Are there any preexisting conditions that would prevent me from getting coverage?

No preexisting condition clauses preclude employees from covered services in any Fairfax County-sponsored health insurance plan. There are several preexisting condition clauses in the dental insurance plans. You may be able to reduce or waive the dental preexisting condition period if you can demonstrate prior dental coverage by attaching a HIPAA certificate with your dental enrollment form. (See HIPAA section under “Benefits under the Law” section on page 20.)

Q: How do I sign up for health or dental benefits?

You are responsible for signing up. Don’t miss the deadline. New employees have 60 calendar days from date of employment to enroll. Enrollment form(s) must reach the Employee Benefits Division (as evidenced by the Division’s date stamp) by the 60th calendar day of employment (see deadline calendar on pages 61-64). It is the employee’s responsibility to ensure that the enrollment form(s) is(are) received by the Human Resources, Benefits Division, by the deadline. It is not the agency’s responsibility. Employees who do not meet this deadline may not enroll until the next open enrollment period unless there is a qualifying change in status event (see page 32).

Your payroll contact can provide you with a packet of health and dental plan information. Additional information is provided at employee orientation and on the Benefits website on the Infoweb.

Q: What is open enrollment?

Each fall, all benefit eligible employees are allowed to enroll, cancel their enrollment, or change their coverage during open enrollment. **This year's fall open enrollment period is Oct. 1 through Oct. 31, 2003.**

Benefit elections are binding for the plan year. **Cancellations or changes are not permitted** during the year unless you have a qualifying change in status event. Qualifying change in status events are explained on page 32.

Employees who are enrolled in the FairChoice+BlueChoice, BluePreferred PPO, Kaiser Permanente or CIGNA health plans and/or any of the dental plans are not required to reenroll. **There are different premiums for each of the plans. If you would like to be in a plan different from the one you are currently in, you will need to submit an enrollment form for the new plan during open enrollment.**

You may change your primary care provider at anytime, provided the new physician or dentist is within your current network and is accepting new patients. Effective dates for provider changes vary by plan. To change your primary care provider, call the plan’s customer service number.

Q: What if I move outside of the service area?

If you are enrolled in the FairChoice+BlueChoice plan and move outside of your designated network's service area, employees may change (retirees *must* change) to the BluePreferred PPO plan or an HMO for which you are eligible. If you are enrolled in an HMO plan and move outside the plan's service area, you may change to another plan or cancel coverage outside of the open enrollment period. The request must be received by the Department of Human Resources within 60 days of the address change. See page 32 for required documentation.

Q: When do enrollments or changes become effective?

The effective date for new health and dental insurance enrollments is the first day of the calendar month following receipt of the enrollment form in the Employee Benefits Division in the Department of Human Resources. The enrollment form may not be submitted prior to your hire date. However, it may take two to three weeks after submission of your enrollment form before you receive identification cards from the health and/or dental plan. (For qualifying events, see pages 32-34.)

Example: Enrollment form of newly eligible employee is received in the Employee Benefits Division any day in the month of July. The coverage will be effective Aug. 1.

If you are a current employee and make changes during open enrollment, changes are effective Jan. 1, 2004.

Q: What if I have to make a change outside of the open enrollment period?

The rules determining the effective dates for coverage type changes (i.e., adding or dropping dependents), and enrollment requests received after the initial eligibility period, are described in the Changes in Status Events Chart on pages 32-34. Enrollment/change requests must be made within 60 calendar days of the qualifying event or coverage loss. See pages 61-64 for specific deadline dates. The enrollment/change request must be consistent with the qualifying event. For example, if your qualifying event is having a baby, it is not consistent to drop coverage for other dependents.

Things to note about coverage changes

- When making changes to your coverage (for example, adding a new baby, dropping a dependent who is no longer eligible), be sure to file the change form with the Employee Benefits Division, Department of Human Resources, **not** with the plan or your agency.

- Whenever the rules allow you 60 calendar days to file a form, your form must actually reach the Employee Benefits Division within 60 days of the qualifying event. The first day of the qualifying event counts as day one. **Filing the form with your agency or putting it in the mail by the deadline does not comply with the enrollment requirements. Forms received after the 60th day will be returned without processing. (See chart on pages 61-64.)**

- Requests for change in coverage may not be submitted in advance. Wait until the event (e.g., birth or marriage) has actually occurred, and then file promptly. See pages 61-64 for specific deadline dates.

Q: What is the plan year?

The plan year is the calendar year. Benefits described in this booklet will be available from Jan. 1, 2004 through Dec. 31, 2004.

Q: What if I leave my position with the County?

If you terminate from County employment or move to a position that is not eligible for benefits, plan coverage ceases at the end of the month of termination or change in status of position. Your termination date is the last day worked or the last day in a paid status in a merit position.

Q: Which coverage should I pick?

The County offers you three levels of coverage: individual (employee only); 2 party (employee and either spouse or eligible dependent child); and family (employee and two or more eligible dependents).

Spouse
You must be legally married to claim your spouse as your dependent. If you are requesting coverage for your spouse, you must submit a copy of your marriage certificate or your tax form, with your enrollment/change form, showing that you filed "married." (See pages 11 for required documentation and eligibility period.) When both husband and wife are County employees, each may enroll only once, either through his/her own enrollment or as a dependent. Double coverage is not allowed.

Dependents
An *eligible dependent child* is defined as any biological child, adopted child, stepchild, or ward under 23 years of age who has never been married and for whom the employee is legally or financially responsible. A grandchild is an eligible dependent if the employee is the legal guardian of the grandchild or if the grandchild's parent (your child) is still your eligible covered dependent.

Financial responsibility means that the employee is providing at least 50 percent of support for the child.

Legal responsibility refers to the employee's status as the parent, stepparent or legal guardian.

A child may continue coverage with the County beyond age 23 if he/she has a severe physical or mental handicap that began before age 23. The employee must complete a disability certification form (which is available from the health/dental plan) and submit it to the Benefits Division in the Department of Human Resources **prior** to the child turning age 23. A child whose eligibility ends because of his/her marriage or employment may not be reinstated. (See COBRA, page 17, for continuation of coverage.)

In addition, children born to your covered unmarried dependent, who is under the age of 23 (i.e. your grandchildren) may be included under family coverage. However, you must be legally or financially responsible for your dependent child and financially responsible for the dependent's child. Clarification: When your unmarried dependent child reaches the age of 23, both the child and the grandchild must be cancelled from your health insurance coverage unless you have documentation showing that you are legally responsible for your grandchild (i.e. adopted grandchild, legal guardian of grandchild, etc.)

A dependent certification form must be completed when the dependent's last name is different from your last name, when the dependent is your grandchild or ward, or when the dependent ceases to be eligible for coverage under your plan.

Q: If the County receives a health insurance order from a child support enforcement agency or the court system, is the County required to enroll dependents in a health plan?
The County is required to enroll any qualified dependent(s) listed on a valid health insurance order into the named employee's County-sponsored health plan. If the employee is not enrolled in a plan, the County will give the employee the opportunity to choose a health plan. If the employee does not enroll the dependent(s) in a plan within the stipulated time frame, the County will enroll the employee and named dependent(s) into the least costly plan offered by the County.

Q: Who pays for employee health benefits?
Each health plan charges a premium for each covered employee. The amount of the premium depends on your status (active or retired), the number of dependents (if any) covered, and the specific plan you choose. The County government pays most of the health insurance premium for active employees, approximately 85 percent of the cost for individual coverage and 75 percent of the cost for 2 party or family coverage. You pay your share of the premium through pre-tax salary deductions. This means you get a tax break because your share of the health care premium is deducted from your pay before income taxes, Social Security and Medicare are calculated. See chart on page 5 for the payroll deduction amounts.

Premiums are deducted pre-tax, biweekly, in the month of coverage. For example: if an employee's coverage becomes effective Jan. 1, the employee's share of January's premium should be taken on the two pay periods in January. Extra deductions may be necessary to cover missed deductions.

Q: What are pre-tax and tax-deferred benefits?

Premiums for health insurance, dental insurance, group term life insurance (premiums for the first $50,000 of coverage) and flexible spending accounts are deducted on a pre-tax basis. This means that the payroll deductions are not included in your taxable income. This means that there are no federal, state or Social Security (FICA) taxes withheld on those deductions.

Tax-deferred deductions (i.e. for retirement and deferred compensation) also are not included in your taxable income. Federal and state taxes are not withheld on these deductions. You will, however, pay taxes when you receive payments from those accounts.

Q: What dental benefits does the County offer?

There are several options for dental coverage. Limited dental coverage is offered through some of the health plans. The CIGNA and Kaiser HMO plans offer limited dental HMO benefits. The FairChoice+BlueChoice plan offers a dental discount program. This dental coverage is included with the health plans and subscribers are automatically eligible for the dental benefits when they enroll in the health plans. There is no dental discount program with the BluePreferred PPO plan.

Employees who need a more comprehensive dental plan may choose to enroll in one of three dental plans: Dental Benefit Providers DHMO, Dominion Dental DHMO, and Dominion Dental PPO. The County does not make a contribution toward the dental premium for this coverage. See pages 8-10 for more information on the freestanding dental plans. You do not need to be enrolled in a health insurance plan in order to enroll in one of the three separate dental plans.

Q: What benefits are available while on Family or Medical Leave?

Under the Family and Medical Leave Act (FMLA), you can take up to 12 weeks of leave annually in the following circumstances: after the birth or adoption of a child, to care for a child, spouse or parent who has a serious health condition, or when a serious health condition prevents you from working. During approved FMLA leave, you and the County must continue to make regular contributions for your health and life insurance premiums. If you want to continue dental coverage, you must also pay the monthly premium for that benefit.

If an employee on Family and Medical Leave fails to return to work prior to termination of employment, the employee may be required to reimburse the County share of the health and life premium paid on his or her behalf during the Family/Medical leave period.

Q: Can I continue my benefits when I'm on Leave Without Pay (LWOP)?

Other than circumstances of approved FMLA Leave, in order for the County to pay the employer's share of your premium, you must be in a paid status (either working or on paid leave) for at least 40 hours in a pay period. If you have less than 40 paid hours for two consecutive pay days in the same calendar month (56 paid hours for firefighters on a 56-hour work schedule, 42 paid hours for 42-hour level pay employees), you must pay the entire monthly premium (County share plus employee share) to maintain continuous coverage. You will be sent a bill for the premium amount owed with a date by which your payment must be received. If you do not make these payments within the time specified, you will be cancelled from the plan(s).

Employees who cancel coverage while on leave without pay (LWOP) may reenroll in the same plan upon returning to work. A request for reenrollment must be made in writing and received by the Employee Benefits Division within 60 days of your return to a paid status for a minimum of 20 hours per week. Coverage will begin the first day of the calendar month following receipt of the enrollment form.

Benefits under the law

COBRA

What is continuation coverage?

Federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) requires that most group health plans (including the County's health plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and the covered dependent children of the covered employee.

Continuation coverage is the same coverage that the County's health plan gives to other participants or beneficiaries who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the County's plan as other covered participants or beneficiaries, including open enrollment and special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the County's health plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator in the Benefits Division in the Department of Human Resources, 12000 Government Center Parkway, Suite 258, Fairfax, VA 22035 (703) 324-3316 of a disability or second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify the COBRA Administrator in the Benefits Division in the Department of Human Resources, 12000 Government Center Parkway, Suite 258, Fairfax, VA 22035 (703) 324-3316 of that fact within 60

COBRA questions?

Contact the COBRA administrator at:

Benefits Division
Department of Human Resources
12000 Government Center Pkwy, Suite 258
Fairfax, VA 22035
(703) 324-3316

days of SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA Administrator in the Benefits Division in the Department of Human Resources, 12000 Government Center Parkway, Suite 258, Fairfax, VA 22035 (703) 324-3316 of that fact within 30 days of SSA's determination.

Second Qualifying Event
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify the COBRA Administrator in the Benefits Division in the Department of Human Resources, 12000 Government Center Parkway, Suite 258, Fairfax, VA 22035 (703) 324-3316 within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Both the employee and the employee's spouse may elect continuation, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not to have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment rights at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similar situation plan

participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed or date received if sent via FAX.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the County's health plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the County's health plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the COBRA Administrator in the Benefits Division in the Department of Human Resources, 12000 Government Center Parkway, Suite 258, Fairfax, VA 22035 (703) 324-3316 to confirm the correct amount of your first payment.

Your first payment should be made payable to Fairfax County and sent to:

COBRA Administrator
Department of Human Resources, Benefits Division
12000 Government Center Parkway, Suite 258
Fairfax, VA 22035

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the 15th of each month for the next month's coverage. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to the address above.

Grace periods for periodic payments

Although periodic payments are due on the 15th of the month, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Can you elect other health coverage besides continuation coverage?

Under the County's health plan, you have the right to elect alternative retiree coverage if you are eligible to retire and receive a benefit from one of the Fairfax County Retirement Plans or if you are an eligible County retiree covered by the

Virginia Retirement System. If you elect this retiree coverage, you will lose all rights to the COBRA coverage. However your spouse and dependents will continue to have COBRA rights if they should lose coverage under the retiree plan due to divorce, legal separation, your death or if your dependent ceases to be eligible for coverage as a dependent. You should also note that if you enroll in the alternative group health coverage you may lose your right under federal law to purchase individual health insurance that does not impose any preexisting condition limitations when your alternative retiree coverage ends. Contact the Fairfax County Retirement Administration Agency at 10680 Main St., Suite 280, Fairfax, VA 22030 (703) 279-8200 or (800) 333-1633 for more information.

For more information

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at *www.dol.gov/ebsa/*.

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all group plans provide certificates of coverage to individuals who cease to be covered for any reason. The certificates of coverage are to be used by individuals who wish to show that they had group health coverage in order to ease the effect of a new plan's preexisting condition limitation period.

Under HIPAA, a preexisting condition period cannot be longer than 12 months (18 months for late enrollment, reduced by previous periods of creditable coverage). Individuals prove periods of creditable coverage by providing the certificates of coverage to their new plan administrator. Since none of the County health insurance plans have preexisting condition limitations, you do not need to provide the County with a certificate when joining a County health plan.

Under HIPAA, periods of creditable coverage prior to a 63-day break in coverage may be disregarded in determining whether that previous period of creditable coverage will reduce a preexisting condition limitation period. If you lose coverage under the County and have a break in coverage of 63 days or more before becoming covered by another group, the new plan can disregard all prior creditable coverage under the County plan in applying its preexisting condition limitation. COBRA coverage in most instances may be used until the coverage is available through a new plan. See the above section on COBRA to determine if you are eligible to continue the coverage with the County under the COBRA group.

HIPAA also requires employers to offer special enrollment periods for certain employees not currently covered under a County health plan. If you are covered under COBRA through another group plan and you choose not to enroll in the County plan when you are initially eligible, you may join a County health plan when your COBRA coverage is exhausted. In addition, if you do not have

HIPAA questions?

For more information on HIPAA, contact Medicare and Medicaid Services (CMS) at: *http://cms.hhs.gov/hipaa/hipaa1/default.asp*; or call (410) 786-1565.

coverage with the County and gain a new dependent by birth, adoption, or marriage, you may enroll your dependent(s) as well as yourself during the special enrollment period (60 days from date of birth, adoption, or marriage). See the chart on page 34 for more information.

If you wish to obtain more information on the HIPAA law, you may contact Medicare and Medicaid Services (CMS) at *http://cms.hhs.gov/hipaa/hipaa1/default.asp*; Phone: (410) 786-1565 (not toll free).

Appendix 1, on page 57 of this booklet, contains information about the protection of individually identifiable health information under the HIPAA Privacy Regulations.

Newborns' and Mothers' Health Protection Act of 1996

This law includes important protection for mothers and their newborn children with regard to the length of hospital stays following the birth of a child. The law stipulates that "Group health plans and health insurance issuers generally may not under Federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under Federal law require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay less than 48 hours (or 96 hours)."

Women's Health and Cancer Rights Act of 1998

This law requires group health plans that provide coverage for medically necessary mastectomies to also provide coverage for:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to provide a symmetrical appearance; and
- prostheses and the treatment of physical complications during all stages of the mastectomy.

The County's plans cover mastectomies and the benefits required by this act.

Your Responsibility

Coordination of Benefits (COB)

Members of County health plans are required to furnish information about any other health coverage they have.

When an individual has coverage under two health insurance plans, Coordination of Benefits (COB) is used to eliminate duplicate payments for the same services. In the case of the FairChoice+BlueChoice and the BluePreferred PPO plans, a coordination method known as "carve out" is used. The plans pay only the difference between the benefits paid by the other plan and what they would have paid if there had been no other coverage. This approach reduces the advantage of carrying coverage under two health insurance plans. When you have other coverage, you must provide authorization to your County health plan to obtain information or recover overpayments from the other plan.

Status changes and fraudulent or erroneous enrollment

At the time you enroll, you must certify that all statements in your application are true to the best of your knowledge. You are responsible for notifying the Employee Benefits Division of any status changes that affect the eligibility of, or premium payments for, any of your dependents (for example, if you and your spouse are divorced, or if a child is no longer a dependent legally or financially).

If it is determined that a person covered in your application was ineligible at the time of enrollment, or later becomes ineligible, coverage for that person will terminate at the end of the month in which he/she became ineligible.

Premiums paid by or on behalf of that person, for up to two months, may be refunded, except that any benefits already paid will be deducted from those premiums. Premiums paid for more than two months will not be refunded. If the costs incurred by the plan significantly exceed the premiums, you may be required to repay the County or the insurance company.

If it is found that an ineligible person was fraudulently enrolled in a plan, or an employee has attempted to claim benefits dishonestly, the County may declare the employee and his/her dependents ineligible to participate in any County-sponsored health plan for up to three years, terminate the employee's employment, or pursue criminal prosecution.

Note: General limitations

No oral statement from any person shall modify or otherwise affect the benefits or terms and conditions of enrollment as set forth in this booklet.

Information about other health coverage must be furnished to the health plan in which you are enrolled, and all necessary documents and authorizations must be completed as requested by the health plan.

Retiree health benefits

If you are covered under a County life, health and/or dental plan at the time of your retirement, you may continue the insurance under the retiree group. You have 60 days after your coverage ends as an active employee to elect to continue your coverage as a retiree. The County reserves the right to change or terminate the benefit provided or adjust the premium at any time. If you are not covered by a County life, health or dental plan at retirement, you are not eligible for retiree coverage.

Most of the information in this booklet applies to retirees as well as active employees. The information in this section is specific to retirees.

If you have retired from Fairfax County, you should contact the Retirement Agency at (703) 279-8200 or (800) 333-1633 for information about continuation of health coverage. The fall open enrollment dates for retirees will be Oct. 1 through Oct. 31, 2003.

If you are currently enrolled in FairChoice+BlueChoice, BluePreferred PPO, Kaiser Permanente or CIGNA and/or any of the dental plans and choose to continue the coverage at the new premium rate, you do not have to submit a form during open enrollment .

If you would like to be in a plan different from the one you are currently in you will need to submit an enrollment form.

If you are currently enrolled in FairChoice+BlueChoice, BluePreferred PPO, Kaiser Permanente or CIGNA and/or any of the dental plans and choose to continue the coverage at the new premium rate, you do not have to submit a form during open enrollment .

For more information, contact:

Retirement Administration Agency
10680 Main Street, Suite 280
Fairfax, VA 22030

(703) 279-8200
(800) 333-1633

FAX: (703) 273-3185

Who pays for retiree life insurance?

The County pays for either 33-1/3 percent or 50 percent of the coverage, depending upon the coverage you have at retirement and the amount you elect to continue at retirement. Retirees who elect to continue either basic or basic plus one times salary optional coverage will pay for 50 percent of the coverage at age banded rates. Retirees who continue basic plus two times salary optional coverage will pay for 66-2/3 percent of the coverage at age banded rates. Retirees who opt to reduce their coverage to $10,000 will pay for 50 percent of the coverage at age banded rates and will have no further contractual coverage reductions. At age 80, retirees may elect to reduce their coverage to $5,000 and will pay for 50 percent of the coverage at age banded rates.

The rates for retirees are four cents less than the age banded rates for active employees because of the discontinuation of the Accidental Death and Dismemberment provision. The monthly premium rates for dependent coverage are the same premium rates that active employees pay. The County does not make a contribution for dependent coverage.

Who pays for retiree health and dental benefits?

Retirees pay the full cost of their health and/or dental insurance premiums. Health insurance premium rates are listed on page 28. Retirees age 55 or older,

or those retired on a disability, receive a monthly subsidy from the County toward the cost of a County health plan. This subsidy is reflected in the table below:

Years of Service At Retirement	Monthly Subsidy for a retiree under age 65	Monthly Subsidy for a retiree age 65 or older (Note: Subsidy payments for retirees over age 65 are adjusted for Medicare)
5-9	$25	$15
10-14	$50	$25
15-19	$125	$75
20-24	$150	$100
25 or more	$175	$125

Retirees currently receiving the $100 subsidy will be grandfathered at that level unless their years of service entitle them to receive a higher monthly subsidy as indicated above.

Surviving spouses are only entitled to a subsidy if they receive a Joint and Last Survivor benefit.

Retirees can pay their share of their health and/or dental insurance premiums in one of two ways.

1. If possible, the cost will be deducted from the monthly annuity in the month prior to the month of coverage.

2. If the individual does not receive an annuity or if the retiree's check is not large enough to cover the monthly premiums, the retiree must pay any amount not covered by their annuity by mailing a personal check to the Retirement Agency by the 10th of the month.

Retirees can pay their share of their health and/or dental insurance premiums in one of two ways. If possible, the cost will be deducted from the monthly annuity in the month prior to the month of coverage. If the individual does not receive an annuity or if the retiree's check is not large enough to cover the monthly premiums, the retiree must pay any amount not covered by their annuity by mailing a personal check to the Retirement Agency by the 10th of the month of coverage. Failure to make health and dental insurance payments on time may result in cancellation of the retiree's insurance coverage. Please remit personal checks, enrollment forms and change forms concerning retiree health/dental coverage to:

Checks should be made payable to:

County of Fairfax

Address is:

Retirement Agency
10680 Main Street, Suite 280
Fairfax, VA 22030
(703) 279-8200 (800) 333-1633 fax: (703) 273-3185

Continuous coverage requirement

The County requires retirees to have continuous cover in a Fairfax County Government (FCG) health and/or dental plan. The County, however, allows the coverage to be transferred from the active County government employee group to the retiree group and vice versa. Transfer to and from the Public Schools is not allowed for purposes of benefits coverage. FCPS is a separate employer. Two examples follow:

Example 1: You are retiring and your spouse is also employed by FCG in a merit position. Your spouse may pick up coverage for both of you and any covered dependents when you retire. If your spouse is already enrolled in a FCG health

plan, he or she may add you to the policy by filing a change form with the Department of Human Resources within 60 days of your retirement date.

If your spouse terminates employment with FCG before qualifying for a retirement benefit, you may pick up the coverage for both of you and any covered dependents through the Retirement Agency by requesting the coverage within 60 days of your spouse's termination date.

Example 2: You retire from FCG, then return to work for FCG in a merit position. The County will transfer your coverage back to the active employee group if you submit a new enrollment form to the Department of Human Resources within 60 days of your reemployment date. The effective date will be the first of the calendar month following receipt of the enrollment form by the Employee Benefits Division. At termination, your coverage will be transferred back to the Retirement Agency if you complete another form requesting coverage through the retirement group.

If coverage is canceled by the retiree or if a retiree's coverage is dropped because premiums have not been paid, the retiree will NOT be eligible to reenroll.

When can retirees make changes to their coverage?

New retirees have the following options within 60 days of retirement:

- They may enroll in Kaiser's Medicare Plus plan if they meet the eligibility requirements outlined on page 26.
- They may also continue in the same health plan that they had as active employees until the next open enrollment period as long as they continue to meet the plan's eligibility requirements. **Note:** CIGNA health plan does not provide any coverage for retirees age 65 and older who are eligible for Medicare.

Current retirees have the following options:

- Retirees enrolled in the Kaiser Permanente Medicare Plus may transfer to another plan if they become ineligible for membership in that plan. Retirees must live in the Kaiser service area to be eligible for coverage in the plan.
- Retirees who move out of their HMO service area must change to another plan serving the area in which they live. The change must be made within 60 days of the move.
- Retirees may **decrease coverage** (drop coverage or drop family members from their insurance) **at any time**. However, levels of coverage may only be increased outside of an open enrollment period **due to a qualifying change in status**. (See pages 32-34)

Retirees may decrease coverage (drop coverage or drop family members from their insurance) at any time. However, levels of coverage may only be increased outside of an open enrollment period due to a qualifying change in status. (See pages 32-34.)

Retirees who wish to continue in a FCG health plan must apply for Medicare Part A and Part B as soon as they are eligible for that federal benefit.

After they receive Medicare coverage, Medicare becomes the primary source for payment of claims, and the FCG health plan becomes secondary.

Retirees eligible for Medicare

Retirees who wish to continue in a FCG health plan **must apply for Medicare Part A and Part B as soon as they are eligible** for that federal benefit. After they receive Medicare coverage, Medicare becomes the primary source for payment of claims, and the FCG health plan becomes secondary.

Retirees or dependents must submit a copy of their Medicare card to the Retirement Agency showing effective dates of Part A and Part B coverage. The monthly premium for Medicare Part B ($58.70 for calendar year 2003) will be deducted from their Social Security Check. Retirees must submit a copy of their Medicare card to the Retirement Agency as soon as it is available – up to three months prior to the effective dates. Submitting a copy of the card in this timely manner will limit the need for any retroactive adjustments in their check.

For most FCG health insurance plans, retirees with Medicare are responsible for paying the same deductible, co-payment, coinsurance and other out-of-pocket expenses that they would have been responsible for paying prior to receiving Medicare. However, under the FairChoice+BlueChoice plan, referrals for specialists are not required.

Retirees and dependents who have Medicare Part A and Part B coverage may be eligible for reduced health insurance premiums. Retirees who do not apply for and maintain Medicare Part A and Part B coverage will be responsible for the portion of their claims that Medicare would have paid.

Coverage for surviving spouses

Surviving spouses of deceased retirees may continue health, life and/or dental insurance coverage until they remarry. Surviving children may continue their coverage until they become ineligible because of age or loss of dependent status. (Under some circumstances, the surviving family member(s) may be eligible for COBRA, see page 17.) If a retiree or dependent with coverage dies, please contact the Retirement Agency as soon as possible so that premiums can be adjusted. Surviving spouses who are age 55 or older and receive a survivor's benefit from the County are also eligible to receive a monthly subsidy (see chart on page 24) . Surviving spouses who do not receive a survivor's benefit are not eligible for any subsidy. If the survivors are not covered under the retiree's plan at time of retirees' death, they are not eligible for coverage.

If a retirement-eligible active employee dies prior to actual retirement, his/her spouse may continue health, life and/or dental insurance through the Retirement Agency until he or she remarries.

If an employee dies prior to becoming eligible for retirement, the survivors are only eligible for continuation coverage under COBRA

If a retirement-eligible active employee dies prior to actual retirement, his/her spouse may continue health and/or dental insurance through the Retirement Agency until he or she remarries. Surviving children may continue their coverage until they are no longer eligible. Surviving spouses of retirement-eligible active employees who are age 55 or older are also eligible to receive a monthly subsidy from the County.

If an employee dies prior to becoming eligible for retirement, the survivors are only eligible for continuation coverage under COBRA.

Kaiser Permanente Medicare Plus Plan

Kaiser Permanente's Medicare Plus plan is available for retirees over 65 who have Medicare Part A and Part B. Retirees with Kaiser coverage are required to

transfer to this plan when they turn 65. Retirees over 65 who are currently enrolled in another plan may enroll with Kaiser Medicare Plus during any open enrollment period. To be eligible for this coverage (which is identical to the standard Kaiser plan) they must live within the plan's service area (and not reside out of the service area for more than 90 days per year). If the retiree or dependent loses eligibility for this plan, the County will allow the retiree to change to another health plan within 60 days of the loss of eligibility so that he/she is covered in a County health plan continuously.

Retirees under the Kaiser Medicare Plus plan must use Kaiser providers in order to receive non-emergency benefits from Kaiser. However, they may use their Medicare card at other providers to receive Medicare benefits for any covered service.

Retirees or dependents who have Kaiser insurance but do not complete the Medicare Plus enrollment form or elect another plan within 60 days of eligibility for Medicare will no longer be eligible for health coverage under a County plan.

Long-Term Care Insurance

Retirees, spouses of retirees, surviving spouses of retirees and adult children of retirees may apply for the coverage at any time. Applicants will need to complete an enrollment form and a medical questionnaire and be approved by Aetna (see Page 51).

Health And Dental Insurance Premiums For Retirees

JANUARY 1, 2004 – DECEMBER 31, 2004

	Full Monthly Premium (before applying any subsidy)
FairChoice+BlueChoice	
Individual	$ 386.63
2 Party	$ 759.79
Family	$ 1,117.41
Individual with Medicare	$ 270.00
2 Party with Medicare	$ 534.36
2 Party (1 Medicare/ 1 Non Medicare)	$ 650.96
Family, 1 Medicare	$ 1,058.71
Family, 2 Medicare	$ 1,000.01
Family, 3 Medicare	$ 941.31
BluePreferred PPO	
Individual	$ 444.61
2 Party	$ 873.76
Family	$1,285.03
Individual with Medicare	$ 310.51
2 Party with Medicare	$ 614.50
2 Party (1 Medicare/ 1 Non Medicare)	$ 748.61
Family, 1 Medicare	$1,226.33
Family, 2 Medicare	$1,167.63
Family, 3 Medicare	$1,108.93
Kaiser	
Individual	$275.10
2 Party	$536.43
Family	$797.77
Individual with Medicare	$231.02
2 Party with Medicare	$462.04
2 Party (1 Medicare/ 1 Non Medicare)	$506.12
CIGNA	
Individual	$305.23
2 Party	$592.95
Family	$886.30
DENTAL BENEFIT PROVIDERS (DBP)	
Individual	$18.42
2 Party	$31.30
Family	$43.38
DOMINION DENTAL (DHMO)	
Individual	$15.56
2 Party	$26.62
Family	$37.74
DOMINION DENTAL PPO	
Individual	$41.28
2 Party	$70.58
Family	$97.42

Health insurance terms defined

Explanations for the terms used in the charts and throughout this booklet are provided below:

BlueChoice - The name of the provider network offered by Blue Cross and Blue Shield of the National Capital Area. BlueChoice was formerly called CapitalCare.

Brand Name Drug - A drug that is sold by one company. It is manufactured by a pharmaceutical company that has chosen to patent the drug's formula and register its brand name. Brand name drugs are generally more expensive than generic drugs.

Coinsurance - After you meet your deductible, the plan will begin to pay a percentage of your covered expenses. This percentage is the plan's coinsurance. The percentage you pay is your coinsurance.

Co-payment - A co-payment, or co-pay, is the amount of the covered expense you are responsible for paying at the time you receive care when you see an HMO provider or a PPO provider.

Covered Services - The insurance contract specifies that certain services are covered and others are not. Those that are covered are generally the kinds of services needed to keep you healthy or take care of you when you are sick or injured. Typical services not usually covered are cosmetic surgery simply to make you look better, rehabilitation for a stroke and long-term treatment for drug or alcohol abuse.

Deductible - This is an amount which you must pay each year in addition to your premiums, before some plans will begin to pay toward your medical costs. This rule is similar to the deductible provision in automobile insurance, under which you pay the first $200 or $500 of the cost of collision damage, and the insurance company pays the rest. If your health plan has an annual deductible of $250, for example, you must pay the first $250 in covered medical expenses each calendar year. After you have paid the deductible amount, the plan begins to pay its share of your covered medical expenses.

Formulary Drug - A list of preferred, commonly prescribed prescription drugs. These drugs are chosen by a team of doctors and pharmacists because of their clinical superiority, safety, ease of use and cost. These drugs are on the middle tier of a 3-tier prescription program.

Generic Drug - A drug that may be sold under more than one name by more than one company. It has the same active-ingredient formula as a brand-name drug. A generic drug is known only by its formula name and its formula is available to any pharmaceutical company. Generic drugs are generally less expensive than brand name drugs.

Health Maintenance Organizations (HMOs) - An HMO emphasizes wellness and preventive care. You pay a flat fee and the HMO covers most of

There are two kinds of HMOs:

In one model, staff doctors and nurses are located at a medical center and generally work directly and exclusively for the HMO. You go to that facility for your appointments. Specialists may be located at the facility or at their own offices elsewhere. Kaiser Permanente is this type of HMO.

The second model is called an individual practice association (IPA). Here doctors have their own offices and you go to the office of your primary care physician for treatment. Your doctor may be a member of more than one IPA-type HMO and also may participate in BCBS and other health plans. CIGNA is this type of HMO.

your medical costs. There are no deductibles, but there may be small co-payments for office visits and prescriptions .

When you join an HMO, you select your primary care physician (PCP) from the HMO's list of doctors or if the HMO is a staff model, you select your center. Your primary care physician is the doctor you usually see whenever you need medical care. (In most HMOs, women may also self-refer to a gynecologist in addition to a primary care physician.)

If you need a specialist, the primary care doctor will refer you to one who is affiliated with the HMO. If you need hospitalization, you will be referred to a hospital that has a contract with the HMO, and usually all your hospital costs will be covered by the HMO. It is important to note that your coverage is with the HMO-plan and not a particular doctor. If your doctor leaves the HMO plan, you must select another provider.

There are two kinds of HMOs:

- In one model, staff doctors and nurses are located at a medical center and generally work directly and exclusively for the HMO. You go to that facility for your appointments. Specialists may be located at the facility or at their own offices elsewhere. Kaiser Permanente is this type of HMO.

- The second model is called an individual practice association (IPA). Here doctors have their own offices and you go to the office of your primary care physician for treatment. Your doctor may be a member of more than one IPA-type HMO and also may participate in BCBS and other health plans. CIGNA is this type of HMO.

In both types of HMOs, you do not have to file claim forms. You make a small co-payment, if applicable, at the time of the visit, and the plan takes care of all the paperwork.

HMOs have specific geographical service areas. While you cannot normally change health plans except during the annual open enrollment period, members who move out of their HMO's service area may switch to the FairChoice+BlueChoice or the BluePreferred PPO plan without waiting for the open enrollment period. The Employee Benefits Division must receive your request for this change and the applicable enrollment forms within 60 days of your change of residence.

Non-Preferred Drug - Term used to identify prescription brand name drugs that are not listed on an insurance company's drug formulary. These drugs are on the 3rd tier of a 3-tier prescription program and have the highest level of co-pay.

Out-of-Pocket Maximum - The most you will pay in coinsurance in a calendar year before the plan pays 100 percent of covered expenses.

Plan Allowance - Plan allowances are generally the contracted rates or fee schedules which participating providers have agreed to accept from the plan as payment under this program. Nonparticipating providers may bill you for any balance above the plan allowance. In any event, you will be responsible for any applicable deductibles and coinsurance and both participating and nonparticipating providers may bill you directly for such amounts.

POS (Point of Service) - An HMO-type plan that allows members to self refer out of the network, subject to higher fees than if care were received from the HMO-type network.

PPO (Preferred Provider Organization) – A network-based, managed care plan that allows the participant to choose any health care provider. However, if care is received from a "preferred" (participating in-network) provider, there are generally higher benefit coverages and lower deductibles.

Pre-certification - An administrative procedure whereby a health care provider contacts the plan before treatment begins.

Premium - A health insurance premium is the amount a health plan charges to provide you with health insurance coverage. Premiums normally are collected monthly, and are divided into two parts, the County's share and the employee's share. For active employees, the County's share is by far the larger of the two. The employee's share, what you pay, is deducted from your biweekly paycheck, prior to taxes, during the month of coverage.

In some special cases described earlier in this booklet, there is no County contribution and the participant pays the entire cost.

Primary care provider - An in-network doctor you choose from a directory of providers. This doctor coordinates the care you receive.

UCR – **"**Usual customary and reasonable" fee. UCR is the amount that is allowed for benefit consideration under out-of-network services. This fee is determined by the plan to be the acceptable maximum in a particular zip code area for a specific procedure. If your physician or dentist charges more than the UCR, the plan will only calculate benefits on the UCR amount. You will be responsible for the difference in addition to your coinsurance.

QUALIFYING CHANGE IN STATUS EVENTS

The following events, as specified in Section 125 of the Internal Revenue Code and other federal regulations, govern the occasions when you can enroll, cancel or change your coverage OUTSIDE of the open enrollment period. The requested change must be consistent with the event. If none of these circumstances exist, requests for change cannot be approved. **NOTE**: A voluntary cancellation is not a qualifying event. Whenever a change form or enrollment form is required, it must be filed with the Employee Benefits Division of the Department of Human Resources within 60 calendar days of the qualifying event or loss of coverage, whichever is later. See chart on pages 61-64 for deadline dates.

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	EFFECTIVE DATE	EXAMPLE
Adoption or placement for adoption	Same as for birth	Change form and legal documentation	Same as for birth.	Same as for birth.
Birth	To enroll a newborn child, a change form must be filed with the Employee Benefits Division within 60 days of birth. Failure to file a change form with the Employee Benefits Division within 60 days of birth will result in coverage for newborn not becoming retroactively effective to the date of birth. (Do not wait for the baby's Social Security Number as it may cause you to exceed the 60 day time limit) • If you do not already have family coverage and the change form is not received within 60 days of birth, the child must wait until the next open enrollment to obtain coverage. • Participants who already have family coverage but fail to enroll a new child within 60 days, may add the child later if the child is less than one year old. Coverage begins the first of the month following receipt of the change form.	Change form and a dependent certification form if you are adding a dependent with a different last name.	Coverage begins on the date of birth if the form is received within 60 days of birth. Beyond 60 days, see section "Employee Action Needed".	Participant has 2 party coverage. Child is born on May 5. Change form is received on July 1. Coverage is retroactively effective to May 5th. Special deductions, if needed, will be taken for the pay periods in which an increase of premiums should have occurred with the change from 2 party to family coverage. Participant has family coverage. Child is born on May 5. Enrollment form is received after the 60th day after the birth of the child but before the child turns one year old. Coverage begins the first of the month following receipt of the change form.
Legal custody or guardianship	Same as for birth.	Change form and copy of final custody order.	Same as for birth.	Same as for birth.
Employee moves and no longer resides within the HMO's service area	To change health plans, file an enrollment form within 60 days of the change of residence. To drop coverage, file a cancellation form within 60 days of change in residence.	Cancellation or enrollment form and documentation showing change in address.	Change/cancellation effective the first of the month following receipt of the forms.	Employee moves out of HMO service area July 5. Cancellation/enrollment form received on July 21. Change/cancellation becomes effective Aug. 1.
Divorce or legal separation	To drop spouse and/or children, file a change form within 60 days of the divorce or legal separation. NOTE: Reconciliation after separation is not a qualifying event to re-enroll a spouse. You will have to wait until the next open enrollment.	Change form and a copy of the legal document supporting the request. NOTE: For legal separation, a property settlement or notarized separation agreement that has been signed by both parties will be sufficient.	Coverage terminates at the end of the month of legal separation or divorce.	Decree date is April 5th. Spouse coverage terminates April 30th. Maximum of four pay period refund if notification to drop spouse is not received within 60 days of divorce or coverage loss.
	If you have lost coverage through your spouse as a result of divorce or legal separation, file enrollment form within 60 days of loss of coverage to pick up coverage with the County.	Enrollment form, copy of the legal document supporting the request and a letter from spouse's health plan or employer showing the date the coverage ended.	No break in coverage is allowed. Effective date is determined by the date coverage is lost.	Date of legal separation is April 5th. If enrollment form is filed within 60 days, coverage begins May 1 (assumes coverage under spouse's plan ended April 30). Special deductions may be necessary.
Death of employee	None	None	Coverage terminates at the end of the month of death.	Date of death is March 14. Coverage ceases March 31.
Death of dependent	File a change form or other written notice. Include date of death on the form.	Change form	Coverage terminates the last day of the month in which death occurs.	Dependent dies on June 1. Coverage terminates June 30. Maximum of four pay period refund if notification is not received within 60 days of death or coverage loss.

QUALIFYING CHANGE IN STATUS EVENTS (continued)

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	EFFECTIVE DATE	EXAMPLE
Spouse terminates employment or takes a leave of absence, and loses coverage through that employer. Employee must have coverage through County or spouse's employer plan.	To pick up new coverage with the County, file an enrollment form within 60 days of loss of coverage. --- To add spouse/dependents who had been covered under spouse's plan to existing County employee's coverage, file a change form within 60 days of loss of coverage.	Enrollment/ change form, copy of marriage certificate or tax return indicating filing married and letter from spouse's employer or health plan showing date coverage ended, reason coverage ended, type of coverage (health and/or dental), name of insurance company and name(s) of covered participants.	No break in coverage is allowed. Date of coverage is determined by the date of coverage loss.	Spouse terminates employment and loses coverage March 30th. Enrollment form and letter must be received by May 29. Coverage will be retroactively effective as of April 1. Special deductions will be taken to cover missed premium payments.
Employee's spouse returns to work or changes employers. Employee will be covered under spouse's new employer's plan.	To request that County coverage be dropped, file a cancellation form within 60 days of the effective date of the new spouse coverage. Note: Must enroll in a separate stand alone dental plan with spouse's new employer in order to drop County's separate stand alone dental plan.	Cancellation form and letter or form from spouse's employer or health plan showing date employment began, date coverage begins, type of coverage (family, two party, individual), name of insurance company and name(s) of covered dependents..	If cancellation form is received within 60 days of the new coverage, coverage with the County will terminate on the last day of the month. No break in coverage allowed.	Spouse becomes covered under new employer on May 1. Form and letter must be received by June 29. (i.e. documentation is received on June 15, coverage is cancelled on April 30). If request is not received within 60 days, participant must wait until next open enrollment to drop.
Marriage	To add a spouse and any eligible dependents, file a change form within 60 days of the marriage.	Change form, copy of marriage certificate or tax return indicating filing married, and if applicable, dependent certification form. You must also notify Social Security and Payroll of any name change.	Coverage begins the first of the month following receipt of the change form.	Date of marriage is April 1. If change form is received by April 30, coverage becomes effective May 1. If form is not received within 60 days of the marriage you must wait until the next open enrollment to add spouse.
	To drop County health plan coverage because you will be covered by new spouse, file a cancellation form within 60 days of the marriage. Note: Must enroll in separate stand alone dental plan with new spouse's new employer in order to drop County separate stand alone dental plan.	Cancellation form and letter from spouse's employer indicating effective date of coverage, type of coverage and name(s) of covered dependents.	If cancellation or change form is received within 60 days of the new coverage, coverage with the County will terminate the last day of the month. No break in coverage allowed.	Date of marriage (and new coverage) is April 1. Form and letter must be received by May 30 (i.e. documentation is received on May 5, coverage is cancelled on March 31). If request is not received within 60 days, you must wait until the next open enrollment to drop.
Employee or dependent becomes entitled to Medicaid or Medicare	File cancellation form to drop coverage within 60 days of Medicaid or Medicare entitlement.	Cancellation form and copy of Medicaid or Medicare entitlement letter.	No break in coverage is allowed. Date is determined by the date of Medicaid or Medicare entitlement.	Date of Medicare entitlement is Aug. 30. Coverage ends Aug. 31. File change form by Oct. 29.
Employee or dependent loses eligibility for Medicare or Medicaid (must be involuntary)	File enrollment/change form within 60 days of coverage loss.	Enrollment/change form, copy of letter indicating loss of eligibility and reason for loss of Medicaid or Medicare coverage and, if applicable, copy of marriage certificate/tax form.	No break in coverage is allowed. Date is determined by the date of coverage loss.	Medicaid coverage ends March 30. Enrollment form and letter must be received by May 29. Coverage effective April 1.
Court orders (including judgements, decrees or qualified medical child support orders)	File change form to add or drop coverage within 60 days of event (change must be consistent with the court order).	Change form, copy of court order and, if applicable, dependent certification form.	No break in coverage is allowed. Date is determined by the date provided in the court order.	Court order is signed Aug. 5. Coverage becomes effective Aug. 5 or coverage will end Aug. 31. Premiums will be charged for the entire month.
Dependent child reaches age 23	To drop an over age dependent, file a change form within 60 days of the 23rd birthday or coverage loss.	Change form	Coverage terminates the last day of the month in which the dependent child turns 23.	Your child turns 23 on May 19. Coverage ends May 31. Must file change form within 60 days of coverage loss to receive full refund if one is due.
Loss of dependent status (does not apply to spouse)	To drop a family member who no longer qualifies as a dependent, file a change form within 60 days of dependent status change.	Change form and dependent certification form indicating that the child is no longer a dependent.	Coverage terminates the last day of the month that the dependent status ended.	Your dependent child, under age 23 marries on June 5. Coverage terminates June 30.

QUALIFYING CHANGE IN STATUS EVENTS (continued)

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	EFFECTIVE DATE	EXAMPLE
Open enrollment of a spouse	If your spouse has a different open enrollment period and different effective date from the County's, you can change your health coverage election so it will correspond with your spouse's. To pick up coverage with the County, file an enrollment form within 60 days of loss of coverage.	Enrollment form, copy of marriage certificate or tax return indicating filing married, and if applicable, dependent certification form. You must also supply a letter from spouse's employer or health plan showing date coverage ends, reason coverage ends, type of coverage (health or dental), name of insurance company and name(s) of covered participant(s).	No break in coverage is allowed. Date is determined by the date of coverage loss.	Date of coverage loss is June 18. Enrollment form and documentation must be received by August 16. Coverage will be effective June 1.
	To drop coverage with the County, file a cancellation form with 60 days of the effective date of the new coverage.	Cancellation form, and letter from employer or health plan showing reason coverage begins, date coverage begins, type of coverage (health or dental), name of insurance company and name(s) of covered participant(s).	No break in coverage is allowed. Date is determined by the effective date of new coverage.	Effective date of new coverage is January 15. Change form and documentation must be received by March 15. Coverage will be terminated effective January 31.

HIPAA SPECIAL ENROLLMENT EVENTS

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	EFFECTIVE DATE	EXAMPLE
Employee or dependent exhausts COBRA or loses coverage due to other involuntary reason, including a dependent's loss of coverage due to reaching a specific age.	File enrollment/change form within 60 days of loss of coverage.	Enrollment form, copy of marriage certificate, if applicable, and letter from employer or health plan showing reason coverage ended, date coverage ended, type of coverage, name of insurance company and name(s) of covered participant(s).	No break in coverage is allowed. Effective date of coverage is determined by the date of coverage loss.	COBRA coverage is exhausted Sept. 30. Form and required documentation must be received by Nov. 29. Coverage is retroactively effective to Oct. 1. (Special deductions will be taken to cover missed payroll deductions.)
Uninsured employee acquires dependent(s) due to marriage	File enrollment form within 60 days of marriage. Enrollment form requesting coverage for employee, spouse and, if applicable, newly eligible dependents (i.e. stepchildren).	Enrollment form, copy of marriage certificate or copy of tax return indicating filing married and, if applicable, dependent certification form.	Coverage begins the first of the month following receipt of the enrollment form.	Date of marriage is April 1. Enrollment form received April 25. Coverage becomes effective May 1. (Special deductions will be taken to cover any missed payroll deductions.)
Uninsured employee acquires dependent(s) due to birth of child or adoption/ placement of child.	File enrollment form requesting coverage for either employee and newly eligible child or employee, spouse and other dependents.	Enrollment form, adoption papers and copy of dependent certification form, if applicable, and copy of marriage certificate or tax return indicating filing married.	Coverage begins on the date of birth if the form is received within 60 days of birth.	Child is born on May 5. Enrollment form is received on July 1. Coverage is retroactively effective to May 5. (Special deductions will be taken to cover missed payroll deductions.)

Deferred Compensation

The County offers a deferred compensation plan to all benefit eligible employees. The County's plan is governed by Section 457 of the Internal Revenue Code. The Code allows employees the opportunity to make contributions into a tax deferred investment account through payroll deductions to save additional money for retirement. The deferred income (biweekly deduction) and the accrued earnings on your investment account are sheltered from federal and state income taxes.

Maximum contributions allowable per calendar year

The 457 plan contribution limit is the lesser of (1) 100 percent of taxable compensation or (2) the normal contribution limit in effect that year.

Beginning in the year you reach age 50, you may make additional annual contributions (as noted in the chart below). The regular catch-up limit is twice the limit in effect for normal contributions ($26,000 for 2004). The catch-up amount is determined by subtracting the actual amount deferred from the maximum amount allowed by law. Regular Catch-Up is only available to employees who are within four years of normal retirement. The contribution limits though 2006 are:

Year	Normal Limit	Age 50 Limit	Regular Catch-up
2003	$12,000	$14,000	$24,000
2004	$13,000	$16,000	$26,000
2005	$14,000	$18,000	$28,000
2006	$15,000	$20,000	$30,000

Rollovers out of or into 457 Plans

This provision allows portability of retirement assets between (to and from) retirement plans (401, 403(b), governmental 457 plans and Traditional IRAs). Participants may roll 457 assets to another plan or IRA when they are eligible to take a distribution from the 457 plan (generally upon separation from service), and only if the distribution is an "eligible rollover distribution." Participants may also request a plan-to-plan transfer from the 457 plan to a defined benefit plan for the purchase of permissive service credit.

Withdrawing your money

You can withdraw assets from your account under the following conditions:

Retirement.

Leaving employment – When you leave your job, for any reason.

Unforeseeable emergency - This is defined as a severe financial hardship resulting from a sudden illness, disability, accidental property loss, or other extraordinary circumstance arising as a result of events beyond your control. This withdrawal option is subject to strict IRS guidelines.

Who to contact

ICMA Retirement Corporation
(800) 669-7400
www.icmarc.org

T. Rowe Price
(888) 457-5770
www.troweprice.com

VALIC
(888) 568-2542
www.agrsretirenet.com /Fairfax

County Benefits
(703) 324-4916

Financial Benefits Help Desk
(703) 324-4995
***Mitch Falte**r, VALIC*
***Craig Brown**, ICMA*

- **S**mall balance account withdrawals **– You are eligible to initiate a one-time disbursement of your account if the balance is $5,000 or less and you did not contribute to the account for at least two years.**

When you can withdraw assets

You can withdraw assets from your account under the following conditions:

- Retirement
- Leaving employment
- Unforeseeable emergency
- Small balance account withdrawal

Is there a penalty?

The 457 plan allows distributions at any age and it does not have a 10 percent penalty tax on distributions received prior to age 59 ½.

The County's investment companies

- ICMA Retirement Corporation – offers 19 funds
- T. Rowe Price – offers 14 funds
- VALIC – offers 15 funds

Flexible 457 distribution rules

457 plan participants have the same flexibility as participants under other plans such as 401(k) plans. This means participants are allowed to stop and restart their distributions as well as to increase and decrease them.

You may choose a beginning payout date at **any time** *after the date* you retire or terminate employment. Your beginning payout date must be no later than April 1st of one of the following: (1) the calendar year in which you reach age 70 ½ or (2) the calendar year you leave employment *whichever is later*. The 457 plan allows distributions at any age and it does **not** have a 10 percent penalty tax on distributions received prior to age 59 ½. If you rolled assets into your 457 plan from another type of plan (i.e. 401, 403(b)), these assets may be subject to the 10 percent penalty tax if you subsequently withdraw them from your 457 plan before you reach age 59 ½.

You have a number of distribution options to choose from (i.e., lump sum, partial lump sum, and scheduled installment payments). You may choose monthly, quarterly, semi-annual or annual payments. You are also allowed to change your distribution at will. This means you can increase, decrease, stop or start your distribution(s) at any time. Contact the deferred compensation vendor(s) you participated with to request a distribution packet or a rollover form.

Investment companies available

There are three investment carriers that offer investments for County employees. Employees are permitted to have accounts with all three carriers. They can also defer biweekly deductions to three carriers at the same time. The three carriers are:

ICMA Retirement Corporation – offers 19 funds
T. Rowe Price – offers 14 funds
VALIC – offers 15 funds

The variety of funds span investment categories – small/mid cap, international, large cap core/growth, large cap value, index, fixed income, money market/stable value/fixed, and asset allocation/portfolio funds. The quarterly returns for the various funds can be found on the County's web site and can be obtained from the Benefits Division in the Department of Human Resources.

Enrollment, change and transfer requests

To enroll in the deferred compensation plan for the first time or with a new vendor, simply complete the form entitled "Fairfax County Government 457 Employee Enrollment Form."

If you are already enrolled but want to change your deduction amount, mailing address or beneficiary, complete the form entitled "Fairfax County Government 457 Change Form".

New enrollments and monetary change requests received by the Department of Human Resources in any month will become effective the first available payday of the next month.

To transfer money from one investment company to another within the County carriers, complete the form entitled “Fairfax County Government Virginia, 457 Deferred Compensation Plan, Request to Move Deferred Compensation Assets Form”. Forms received by the last Tuesday of the month are processed the first Friday of the following month.

Forms can be requested from the Benefits Division of the Department of Human Resources, from your agency payroll contact or downloaded from the County’s Infoweb.

Anytime you want to change your investment allocations or transfer money between funds within the same carrier, simply call the carrier on the 800 number:

ICMA Retirement Corporation	(800) 669-7400
T. Rowe Price	(888) 457-5770
VALIC	(888) 568-2542

Allocation changes and fund transfers will be effective the same day if requested by 4 p.m. If after 4 p.m., changes will be effective the next business day.

Financial Benefits Help Desk

If you have general questions about deferred compensation, you may call the Help Desk at (703) 324-4995. The Help Desk is located in the Department of Human Resources and is manned five days a week by a deferred compensation representative from VALIC or ICMA-RC.

Flexible Spending Accounts

Benefit eligible employees have the opportunity to participate in two flexible spending accounts: the Dependent Care Assistance Program and the Medical Spending Account. These accounts allow you to set aside funds on a pre-tax basis to reimburse yourself for out-of-pocket dependent care or medical expenses. Because the dollars you place in these accounts are taken out of your pay before they are taxed, you lower your taxable income, thereby saving on Social Security taxes and state and federal income taxes.

You elect to place a designated amount of pre-tax dollars in your flexible spending account(s) for the plan year. The dollars you place in these accounts will be deducted over 25 pay periods during the plan year usually starting on the second pay date in January. When you submit proof of an eligible expense, you will be reimbursed from your account. Any unpaid dependent care claims (due to expenses exceeding the amount in your account at the time of the claim) will be paid out automatically as money accumulates in your account.

Changes to your deduction amount can only be made when there is an eligible change in family circumstances. You must re-enroll during open enrollment for the next plan year.

Use It or Lose It Rule: IRS rules state that if you don't use all of the money in your account within the plan year, those funds will no longer be available to you. It is important to be sure you don't contribute more than your projected expenses. The worksheet included in the enrollment kit will assist you in computing the amount needed to participate in the dependent care and/or medical spending accounts.

Dependent Care Assistance Program

You can elect to set aside up to $5,000 to pay for childcare or the care of an incapacitated spouse or other dependent (such as an elderly parent). These expenses must be necessary for you or you and your spouse to work. Daycare center charges, family daycare, summer day camp, before and after school care, pre-school and au pair expenses are examples of eligible expenses.

Medical Spending Account

You can elect to set aside up to $5,000 to pay for out-of-pocket medical expenses by using the medical spending account. These expenses may be for yourself, your spouse and your dependents for income tax purposes, whether you participate in a County health plan or not. Deductibles, copayments, prescriptions, contact lenses, eyeglasses, orthodontia and other expenses not covered by your health or dental insurance are examples of eligible expenses.

Who to contact

Ceridian
Customer Service
(877) 799-8820
www.ceridianfsa.com

County Benefits
(703) 324-4916

Things to know

Re-enroll
Every year you must re-enroll into the flexible spending programs during open enrollment for the next plan year.

Use it or lose it rule
IRS rules state that if you don't use all of the money in your account within the plan year, those funds will no longer be available to you. It is important to be sure you don't contribute more than your projected expenses.

Maximum/Minimum

Dependent Care Assistance Program

$5,000 Maximum annual contribution (regardless of number of dependents)
$2,500 Maximum annual contribution for married individuals filing separately
$125 Minimum annual contribution

Medical Spending Account

$5,000 Maximum annual contribution
$125 Minimum annual contribution

Eligibility

Benefit eligible employees have 60 days from their eligibility date to enroll in the flexible spending accounts. They become effective under the plan the first of the month following receipt of the enrollment form. An eligible dependent is any person considered a dependent under Section 152 of the Internal Revenue Code.

Termination of your flexible spending account

Your flexible spending account will terminate on the earliest of the following dates:

- The date that your required contributions are discontinued, or
- The date the plan is terminated.

Upon termination of the flexible spending account, you will have a grace period (as specified in "Grace Periods" section) during which to submit claims for reimbursement for expenses incurred before your termination date.

Eligible claims must be incurred during the plan year. According to current IRS rules, an expense is considered incurred when service is actually received, not when you are billed or pay for the service.

Grace periods

For active employees: You have 90 days following the plan year to submit claims that you incurred during the previous plan year.

For terminated (this includes those retiring) employees: You have 90 days following your termination from the plan to submit claims for expenses incurred while you were participating.

Reimbursements

Claims are paid biweekly (as specified in the reimbursement schedule you receive when you enroll and available on the Infoweb).

The Medical Spending Account and Dependent Care Assistance Program are separate accounts. Funds cannot be transferred from one account to the other. Eligible claims must be incurred during the plan year. According to current IRS rules, an expense is considered incurred when service is actually received, not when you are billed or pay for the service.

The Medical Spending Account and Dependent Care Assistance Program are separate accounts. Funds cannot be transferred from one account to the other.

COBRA for the Medical Spending Account

If you are participating in the Medical Spending Account at the time of a COBRA qualifying event, you may elect to continue your coverage in that

account under COBRA. If the Medical Spending account is continued under COBRA, charges incurred during the period of continued coverage are eligible for reimbursement as long as the participant continues to contribute to the Medical Spending account. Once contributions cease, participation in COBRA ends automatically.

Family status changes

When you have a status change that alters your coverage needs, you must submit a new election form and documentation of the family status change to the Benefits Division in the Department of Human Resources. Your form must be received within 60 days from the date of the event. See pages 61-64 for specific deadline dates. Call the Benefits Division (324-4916) or go to the County Infoweb for a package of information on the flexible spending accounts, which includes information on allowable family status changes.

Term life insurance

Term life insurance is an important building block in your family's foundation of financial security. Although there is no cash value from which to borrow, it gives your family a base of protection that can be supplemented by personal savings and Social Security benefits.

You receive a Basic employer-paid benefit and can choose to participate in an optional employee-paid benefit.

Who to contact

For more information on term life insurance call:

(703) 324-3374
or (703) 324-3437

What benefits are available to you?

- Basic employer-paid insurance, equal to one times your annual salary rounded to the next higher $1,000, up to a maximum of $200,000. Fairfax County Government pays the total cost of this program.

- Optional employee-paid insurance is paid by you through convenient payroll deductions. You can apply for one or two times your salary, rounded to the next higher $1,000. Optional coverage up to $325,000 is offered to you on a guaranteed basis if you apply when first eligible. After you become insured, all future increases due to increases in your salary are guaranteed up to the plan maximum of $500,000. Coverage amounts will be increased or decreased due to age or salary changes on Sept. 1 based on your annualized salary.

Cost of the term life insurance

The cost of the optional plan is outlined below:

Age	Monthly Premium Rate per $1,000 of coverage
Under 30	$0.12
30-49	$0.21
50-59	$0.34
60-79	$0.53
80-84	$4.28

Benefit Example:
You are 40 years of age and have an annual salary of $40,000. You are provided Basic coverage equal to one times your salary. You elect optional coverage of two times your salary. Your total insurance coverage is $120,000 ($40,000 Basic, $80,000 Optional). Your premium is $16.80/month or $8.40 biweekly. Since most of this is a pre-tax benefit, your net pay is reduced by less than the biweekly cost.

What benefits are available to my family?

Additional coverage is available for your family under this program. If you apply when first eligible, you may choose coverage for your family on a guaranteed basis. You can choose between two coverage options to insure your spouse and children.

Children from birth to nine days have a reduced benefit of 10 percent of the coverage amount.

Coverage Amount	
Spouse/Child	*Monthly Premium*
$5,000/$2,000	$2.50
$10,000/$5,000	$5.00

Coverage ceases when a dependent child reaches age 19. Notify the Department of Human Resources when a dependent child reaches age 19 so that the ineligible dependent child can be removed from the policy.

Do I have accidental death and dismemberment benefits?

Yes. Both the Basic and Optional programs double your life insurance amount if you die as a result of an accident. Refer to the benefit schedule in the policy for dismemberment that results from bodily injury. This benefit terminates at retirement.

What is the accelerated death benefit?

If you become terminally ill, with life expectancy of less than 12 months, you may withdraw a portion of your death benefit or the full amount, less any charges, while you are living. There are no limitations on how you spend the money.

How to sign up for term life insurance benefits

Every benefit-eligible employee needs to complete a group term life enrollment card. You need to choose your coverage amount and designate your beneficiary(ies).

You have 180 calendar days from your date of employment or eligibility to request guaranteed optional and dependent coverage. Your enrollment card must reach the Department of Human Resources by the 180th calendar day. (See pages 61-64.)

Your coverage will be effective at the beginning of your seventh month of employment. If the Department of Human Resources receives the card after the 180th day, you will only qualify for basic employer-provided coverage. You may apply for the additional optional coverage during open enrollment, but it is not guaranteed.

Benefit reduction schedule

Coverage reduces to 65 percent of the original amount at age 65, or retirement, whichever occurs first. It reduces again to 30 percent of the original amount at age 70. These reductions occur Sept. 1 following:

- your retirement or your 65th birthday (whichever occurs first); and
- your 70th birthday.

You have 180 calendar days from your date of employment or eligibility to request guaranteed optional and dependent coverage.

Your enrollment card must reach the Department of Human Resources by the 180th calendar day. (See pages 61-64.)

Coverage reduces to 65 percent of the original amount at age 65, or retirement, whichever occurs first.

It reduces again to 30 percent of the original amount at age 70.

Coverage termination

If you terminate your employment, your coverage will continue until the end of the calendar month in which you terminate. You may elect to convert your coverage and any family coverage you have to individual whole life policies on a guaranteed basis within 31 days of coverage termination. Call (703) 324-3437 for the conversion form.

What changes can you make during open enrollment?

- You may decrease or cancel your Optional coverage.
- You may apply for Optional coverage (either one times or two times your salary). The increase in Optional coverage will be contingent upon approval by Minnesota Life.
- You may apply for dependent coverage. Additional dependent coverage will be contingent upon approval by Minnesota Life.

The necessary forms can be obtained from your agency payroll contact, from the Benefits Division in the Department of Human Resources, Suite 258, Government Center, or the Infoweb.

What changes can you make outside open enrollment?

- Add dependent coverage due to a qualifying event.
- Cancel dependent coverage at anytime.
- Reduce Optional coverage if the reduction would result in optional coverage of at least $50,000 still in place.
- Change beneficiary(ies). See your agency payroll contact for a Change of Beneficiary Form, contact the Benefits Division at (703) 324-3437 or go to the County's Infoweb.

Universal life insurance

Group Universal Life insurance provides life insurance that you or your spouse can continue even if you change jobs or retire. With Group Universal Life, you can also choose a cash value account that earns interest on a tax deferred basis.

Who is eligible?

Benefit eligible employees and their spouses.

How much insurance is available?

You and your spouse may apply for insurance amounts between $10,000 and $500,000.

Is the insurance guaranteed?

Newly hired benefit-eligible employees may apply for up to $100,000 of guaranteed insurance if you apply within 60 days of your original hire date. See pages 61-64 for specific deadline dates.

Your spouse may apply for $50,000 of guaranteed insurance if he or she applies for coverage within 60 days of your original hire date, or within 60 days of marriage. Your spouse is eligible for this coverage even if you choose not to cover yourself. Your spouse must also be working outside the home at least 20 hours per week to be eligible for guaranteed insurance. If your spouse did not apply when you were first eligible, he or she must complete the enrollment application and an evidence of insurability form.

If you or your spouse did not apply when you were first eligible, either one may apply for the coverage at any time throughout the year. The coverage is not guaranteed. It will require plan approval.

Cost

The rates below are shown monthly per $1,000 of insurance coverage and are payroll deducted. The cost of insurance increases with your age. The premiums shown do not build cash value. A non-tobacco status is defined as an applicant who has not used tobacco in any form during the 12 months prior to the date of application.

Who to contact

For more information on universal life insurance call

Customer Service
(800) 843-8358

County information line
(703) 324-3374
(703) 324-3437

Age	Non-Tobacco	Tobacco
Under 30	$0.15	$0.30
30 – 34	0.15	0.32
35 – 39	0.16	0.38
40 – 44	0.20	0.51
45 – 49	0.30	0.74
50 – 54	0.47	1.08
55 – 59	0.74	1.71
60 – 64	1.30	2.73
65 – 69	2.19	4.08
70 – 74	4.10	6.41
75 – 79	6.29	9.37
80 – 84	10.03	12.83
85 – 89	14.39	17.10
90 – 94	21.42	23.69

Cash value illustration

You can choose to build cash value in your group universal life plan. To request a free illustration, complete the Illustration Request form found in a Group Universal Life folder and return it to Minnesota Life, or call toll free (800) 843-8358.

Children's coverage

You may insure each of your dependent children (ages 14 days to 23 years) with a $4,000 term life insurance rider. The cost is $1.00 per month regardless of the number of children insured. Children's insurance can be added to your application OR your spouse's application.

How to enroll

If you are interested in applying for coverage, see your payroll contact for an enrollment kit or contact the Employee Benefits Division. Premiums are deducted biweekly on a post-tax basis. Changes can be made at any time of the year but may be contingent upon approval for coverage by Minnesota Life when increases in coverage are requested.

Conversion

If you wish to continue this insurance after termination of employment or retirement, call Minnesota Mutual at (800) 843-8358 ext 4848 to make arrangements for direct payment.

How to enroll

If you are interested in applying for coverage, see your payroll contact for an enrollment kit or contact the Employee Benefits Division.

- Enrollment forms are mailed directly to the vendor.
- Premiums are deducted biweekly on a post-tax basis.
- Changes can be made at any time of the year but may be contingent upon approval for coverage by Minnesota Life when increases in coverage are requested.

Long-term disability salary insurance

The County offers a voluntary group long-term disability insurance plan which provides a monthly benefit in the event of accident or extended illness. The amount of the benefit depends upon the employee's salary and the extent to which other sources of disability income are utilized. The plan pays a benefit up to 60 percent of an employee's monthly basic earnings – to a maximum of $2,500. Your benefit amount is reduced by any amounts payable to you by any of the sources listed in the detailed enrollment brochure. For example, the long-term disability benefit will be reduced by Social Security retirement and/or disability benefits payable to you. However, your benefits from this plan will never be less than $100 per month. Since the deductions are taken post tax, you will not pay taxes on the monthly benefit.

How and when to enroll

Enrollment forms must be submitted within 90 days from date of hire or eligibility to be guaranteed coverage. See pages 61-64 for specific deadline dates. You may apply at any time, but after the initial 90-day enrollment period, you will need to complete an evidence of insurability form.

Cost

Premiums are based on age and salary. The County makes no contribution toward the cost of this insurance. The premiums are detailed on the next page.

Effective date

The insurance will become effective the first of the calendar month following the first 90 days of employment. If you apply after your first 90 days of employment, your effective date (if approved) will be determined by CIGNA, the administrator of the County's long-term disability plan.

Benefit waiting period

Before collecting benefits, you must satisfy a 90-day benefit waiting period. Hence, benefits are payable on the 91st day of disability.

Limitations

Please see the detailed brochure for language pertaining to preexisting conditions, limitations to Mental/Nervous Conditions and Drug/Alcohol Abuse and exclusions.

Conversion

If you are terminating from County employment and have had long-term disability insurance for at least 12 consecutive months, you are eligible to convert to Disability Conversion Insurance. You have 31 days from date of termination to submit an application without evidence of good health. If you apply for the new coverage after 31 days but not more than 62 days after your termination of employment date, you will be required to supply evidence of insurability.

Who to contact

For more information on long-term disability salary insurance call:

CIGNA LTD
Customer Service
(800) 992-3522

County information line
(703) 324-3437

LTD ESTIMATED MONTHLY PREMIUM CHART

Monthly Salary	Ages 18-24	Ages 25-29	Ages 30-34	Ages 35-39	Ages 40-44	Ages 45-49	Ages 50-54	Ages 55-59	Ages 60-64	Ages 65-69
Less than $833	$1.49	$1.81	$2.02	$2.37	$4.45	$6.73	$9.17	$9.88	$10.14	$12.84
$833-$999	$1.82	$2.21	$2.46	$2.90	$5.44	$8.21	$11.20	$12.06	$12.38	$15.68
$1,000-$1,166	$2.15	$2.62	$2.92	$3.43	$6.45	$9.73	$13.28	$14.29	$14.68	$18.59
$1,167-$1,332	$2.50	$3.04	$3.39	$3.98	$7.48	$11.30	$15.40	$16.59	$17.03	$21.56
$1,333-$1,499	$2.85	$3.47	$3.87	$4.55	$8.55	$12.91	$17.60	$18.95	$19.45	$24.64
$1,500-$1,666	$3.22	$3.92	$4.37	$5.13	$9.64	$14.56	$19.86	$21.39	$21.95	$27.80
$1,667-$1,832	$3.59	$4.37	$4.87	$5.73	$10.76	$16.25	$22.17	$23.86	$24.50	$31.03
$1,833-$1,999	$3.98	$4.84	5.39	$6.35	$11.91	$17.99	$24.54	$26.43	$27.12	$34.36
$2,000-$2,166	$4.37	$5.33	$5.93	$6.97	$13.10	$19.78	$26.98	$29.05	$29.81	$37.77
$2,167-$2,332	$4.78	$5.81	$6.48	$7.62	$14.30	$21.60	$29.46	$31.72	$32.56	$41.24
$2,333-$2,499	$5.19	$6.32	$7.04	$8.28	$15.54	$23.47	$32.01	$34.47	$35.38	$44.82
$2,500-$2,666	$5.62	$6.84	$7.61	$8.95	$16.81	$25.39	$34.63	$37.29	$38.28	$48.49
$2,667-$2,832	$6.05	$7.36	$8.19	$9.64	$18.11	$27.34	$37.29	$40.15	$41.21	$52.21
$2,833-$2,999	$6.49	$7.90	$8.79	$10.34	$19.43	$29.34	$40.02	$43.09	$44.23	$56.03
$3,000-$3,166	$6.94	$8.46	$9.41	$11.07	$20.79	$31.39	$42.82	$46.10	$47.32	$59.95
$3,167-$3,332	$7.41	$9.01	$10.03	$11.80	$22.17	$33.66	$45.65	$49.15	$50.45	$63.91
$3,332-$3,499	$7.87	$9.59	$10.67	$12.56	$23.58	$35.61	$48.56	$62.29	$53.68	$67.99
$3,500-$3,666	$8.36	$10.17	$11.32	$13.33	$25.02	$37.79	$51.53	$55.49	$56.96	$72.11
$3,667-$3,832	$8.85	$10.77	$11.98	$14.11	$26.48	$39.99	$54.55	$58.74	$60.29	$76.37
$3,833-$3,999	$9.35	$11.38	$12.67	$14.90	$27.99	$42.26	$57.64	$62.06	$63.71	$80.70
More than $4,000	$9.86	$12.00	$13.36	$15.72	$29.51	$44.57	$60.80	$65.45	$67.19	$85.11

Premiums are shown monthly. To calculate the bi-weekly premiums, simply divide by 2.

Long-term Care Insurance

Long-term care refers to services you may need if you become unable to care for yourself. This plan provides a daily benefit when you are unable to perform at least two of six activities of daily living: bathing, dressing, eating, transferring, toileting, and continence or when you have a severe cognitive impairment such as Alzheimer's disease. Your benefits begin after a single 90-day waiting period. You choose where you want care: at home, an assisted living facility, nursing home, adult day care and hospice.

Detailed information on the plan is available in the Outline of Coverage Booklet included in the Enrollment Kit. The following information provides a brief overview of the plan.

Eligibility

You are guaranteed the coverage if you enroll within 60 days of benefit eligibility. If you apply after your initial eligibility period, you will need to complete an enrollment form and a medical questionnaire. Coverage for late enrollees will require plan approval.

Retirees, spouses of employees and retirees, surviving spouses of retirees, adult children of employees or retirees, as well as parents or parents-in-law, grandparents or grandparents-in-law of employees may apply for the coverage at anytime. Applicants will need to complete an enrollment form and a medical questionnaire and be approved by Aetna.

How and when to enroll

You may enroll online at *www.aetna.com/group/fairfaxCounty* if you apply within 60 days of benefit eligibility. You are guaranteed coverage if you apply within 60 days. Retirees and family members can download forms from Aetna's website or call the Aetna hotline at (800) 537-8521 or DHR, Employee Benefits at (703) 324-3437 for enrollment kits. Completed enrollment and medical questionnaire forms (if applicable) should be returned directly to Aetna. After processing your enrollment, Aetna will mail the insured a certificate of coverage booklet.

Effective date

The effective date for newly eligible participants is the first of the month following the date Aetna approves and processes the enrollment form.

Who to contact

Aetna
(800) 537-8521
www/aetna.com/group/fairfaxcounty

County Benefits
(703) 324-4915
(703) 324-4916
(703) 324-3437

Long-term care plan design

You can choose from three core plans or you can customize your own plan. Key components of each plan are described below:

Benefit/Feature	Plan A	Plan B	Plan C	Customized
Daily Benefit Amount (DBA)	$100	$200	$250	$100, $150, $200, $250
Lifetime Maximum Pool of Money*	$109,500 (3 years)	$219,000 (3 years)	$456,250 (5 years)	$109,500 to $456,250 (3 or 5 years)
Home Care and Community Care	50% of DBA	50% of DBA	75% of DBA	50% or 75% of DBA
Inflation Protection	Voluntary: 5% compounded every 3 years	Voluntary: 5% compounded every 3 years	Voluntary: 5% compounded every 3 years	Voluntary: $1 increments Up to 5% of the plan maximum compounded every 3 years Automatic: 5% of your current DBA annually.
Benefits Bank (If premium payments are stopped after 3 years, you may have a benefit if you go into claim status.)	No	No	Yes	Optional
Return of Contribution (Premiums may be returned to your beneficiary upon your death.)	No	No	Yes	Optional
Limited Pay (Premiums are paid up at age 65 or 10 years, whichever is greater.)	No	No	No	Optional

* Based on when and where you receive care, your lifetime maximum benefit could be paid out in a minimum of 3 or 5 years. If your daily services cost less than your daily benefit amount or you do not need to receive services every day, your benefits will last longer than your benefit period. For example, if you choose a 3-year plan with a DBA of $300 and then receive covered services reimbursed at $150 a day, your pool of money would be exhausted in six years.

Covered expenses

If you become eligible for benefits, the plan will reimburse you for bills submitted for covered expenses up to your Daily Benefit Amount (DBA), or a percentage of your DBA as indicated below:

Nursing Home or Hospice Facility Care	Actual Expenses up to 100% of DBA
Assisted Living Facility Care	Actual Expenses up to 100% of DBA
Adult Day Care:	Actual Expenses up to 50% or 75% of DBA
Community-Based Hospice Care	Actual expenses up to 50% or 75% of DBA
Home Health Care	Actual expenses up to 50% or 75% of DBA
Community Based Care	Actual expenses up to 50% or 75% of DBA
Alternate Care	Actual Expenses up to 50% or 75% of DBA
Bed Reservation	100% of DBA for 21 days per calendar year

Additional benefits that **do not** reduce your lifetime maximum are noted below:

Transitional Care	One time payment equal to 3 times the DBA
Informal Care	25% of the DBA for up to 50 days per calendar year
Informal Caregiver Training	One payment per claim period equal to cost of training up to 3 times the DBA
Respite Care	50% of the DBA for up to 21 days per calendar year.

Premiums

The premium for long-term care coverage will vary depending upon the covered person's age at the time of application and the choice of benefit options. The premium rate tables are in the Outline of Coverage Booklet included in the Enrollment kit. Premium rates for all plan options can be computed on the online calculator at Aetna's website for our group plan. A covered person may choose between the following premium payment options: payment over the entire term of coverage or payment to the later of age 65 or a 10 year period.

The County makes no contribution toward the cost of long-term care insurance. Employees will have payroll deductions for themselves and their spouses. All others will be directly billed by Aetna. The plan waives the premium when the insured is receiving benefits. In addition, the plan has a 30-day free look provision. This means the premiums will be refunded if you cancel your plan within 30 days of receiving the certificate of coverage booklet.

Sample Comparison of Monthly Premium Rates
(refer to website for complete list)

Age	Plan A	Plan B	Plan C
45	$14.30	$ 28.60	$ 56.25
47	$16.20	$ 32.40	$ 62.50
52	$22.40	$ 44.80	$ 84.50
58	$37.90	$ 75.80	$138.00
63	$60.80	$121.60	$212.50

Plan changes and cancellations

You may increase your coverage at anytime with plan approval. You may also elect to cancel your coverage or decrease your coverage at anytime. Call Aetna's hotline at (800) 537-8521 for assistance with your change and cancellation requests. Aetna will notify the County of plan and premium changes.

Continuation of coverage

When you leave the County, you can continue your coverage at the same group rate by paying premiums directly to Aetna.

Virginia College Savings Plans

Employees have the opportunity to participate in three Section 529 college tuition savings plans offered by the Commonwealth of Virginia: the Virginia Prepaid Education Program (VPEP), the Virginia Education Savings Trust (VEST), and CollegeAmerica. Each plan provides significant tax advantages: (1) earnings grow tax free, (2) withdrawals for college expenses are tax free and (3) residents of Virginia can deduct the entire investment, over time, on their Virginia tax returns. A brief description of each plan follows:

- **VPEP** locks in future college costs for today's students in the ninth grade or younger. Contract payments are invested so that their steady growth will cover full tuition and mandatory fees at Virginia public colleges and universities. This plan has a guaranteed rate of return for other types of colleges nationwide.

- **VEST** offers 12 no-load investment options, which include four Vanguard mutual funds. Students of all ages can participate wherever they live. You can use VEST to pay for all major college expenses. These include tuition, fees, room and board, textbooks, required computers and supplies.

- **CollegeAmerica** gives investors a choice of 21 American funds in four share classes, including one for employer-sponsored programs with significantly lower fund management fees. You can use CollegeAmerica assets to pay for tuition, fees, room and board, textbooks, required computers and supplies.

Who to contact

VPEP and VEST
(888) 567-0540
www.Virginia529.com

CollegeAmerica
(703) 324-4995

Enrollment period

VPEP has a limited enrollment period each year. The period generally runs from late January through May 1 of each year and deductions begin in August. VEST and CollegeAmerica are open all year. Meetings with the plan representatives will be scheduled during the VPEP open enrollment.

Plan information

VPEP and VEST enrollment kits and forms are available from DHR as well as the Virginia College Savings Plan. Employees with specific questions on VPEP or VEST are encouraged to call the Virginia College Savings Plan at (888) 567-0540 or visit their website at *www.Virginia529.com*. Employees interested in the College America Plan may call the Financial Benefits Help Desk at (703) 324-4995, TTY (703) 222-7314. Craig Brown, ICMA-RC representative and Mitch Falter, VALIC representative will both act as financial advisors for the CollegeAmerica Plan and will provide enrollment kits and plan information upon request.

Fees

The County has agreed to sponsor the Virginia College Savings Plan to provide employees with reduced application fees for VPEP and VEST (from $85 to $25) and significant savings on investment fund expenses in CollegeAmerica. To qualify for the lower fees, employees must use the automatic payment authorization forms noting the County's group number and agree to automatic debits from a checking or savings account. The VPEP and Vest automatic payment authorization forms are on the Infoweb and available in DHR. The CollegeAmerica forms with the County group number are available from the Financial Benefits Help Desk.

APPENDIX 1- HIPAA Privacy Rules
PROTECTION OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Section 1 -- GENERAL

Section 1.1 Limited Applicability. This Appendix 1 is for the sole and limited purpose of complying with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR § 164.102 *et seq.*, as amended from time to time, and any successor thereto (the "Privacy Rule"). This Appendix 1 shall not affect, or be taken into account in determining the benefits under the Plan with respect to any individual. To the extent that any of these provisions are no longer required, they shall be deemed deleted and shall have no further force or effect.

Section 1.2 Interpretation. This Appendix 1 is intended to comply with the Privacy Rule and shall be construed in a manner that will effectuate this purpose. This Appendix 1 shall not be construed in a manner that is inconsistent with the stated purpose.

Section 1.3 Effective Date. The effective date of this Appendix 1 is April 14, 2003.

Section 2 -- DEFINITIONS

Section 2.1 General. For purposes of this Appendix 1, the following terms shall have the meanings given to them below. To the extent not defined for purposes of this Appendix 1, capitalized terms shall have the meanings given to them in the Plan.

"De-identified Information" shall be defined as individually identifiable health information that has been de-identified in accordance with the requirements of 45 CFR § 164.514(b), or any successor thereto. De-identified Information is not subject to the Privacy Rule.

"Health Maintenance Organization" shall be defined as it is in 45 CFR § 160.103, or any successor thereto.

"Health Insurance Issuer" shall be defined as it is in 45 CFR § 160.103, or any successor thereto.
"PHI" shall be defined as it is in 45 CFR § 164.501, or any successor thereto.

"Participation and Enrollment Information" shall be defined as the information described in 45 CFR § 164.504(f)(1)(iii), or any successor thereto.

"Plan Administration Functions" shall be defined as those activities, and only those activities, that both (i) meet the definition of "payment" or "health care operations" under 45 CFR § 164.501, or any successor thereto, and (ii) are listed in Section 5.1 hereof.

"Plan Sponsor" shall be defined as it is Section 3.1 hereof.

"Privacy Official" shall be defined as it is in Section 4.1 hereof.

"Settlor Functions" shall be defined as the functions described in 45 CFR § 164.504(f)(1)(ii)(A) and (B), or any successor thereto.

"Summary Health Information" shall be defined as it is in 45 CFR § 164.504(a), or any successor thereto.

Section 3 -- PLAN SPONSOR

Section 3.1 Identity of Plan Sponsor.

a. The County shall be the Plan Sponsor for purposes of the Privacy Rule when performing Plan Administration Functions or Settlor Functions, when acting on behalf of the Plan with respect to its obligations under the Privacy Rule, and when acting on behalf of the Plan's participants and beneficiaries with respect to Participation and Enrollment Information.

b. The Chief, Benefits Division of the Department of Human Resources shall act for the Plan Sponsor, and shall be entitled to delegate its powers and responsibilities in accordance with its usual practices.

c. Individuals and classes of individuals identified in Section 5.2 hereof shall be considered part of the Plan Sponsor.

Section 3.2 -- Responsibilities and Undertakings.

a. The Plan Sponsor shall be responsible for making any necessary certifications to the Plan. Such certifications shall be delivered to the Plan's Privacy Official.

b. The Plan Sponsor also undertakes and agrees that it:

(i) Shall not use or disclose PHI except as specified in Section 5 of this Appendix 1.

(ii) Shall require any agents or subcontractors to whom it discloses PHI to agree to the same restrictions on the use and disclosure of PHI as apply to the Plan Sponsor;

(iii) Shall not use or disclose PHI for any employment-related actions of the Company;

(iv) Shall not use or disclose PHI in connection with any other benefits or benefit plan, program, or arrangement of the Company (except to the extent that such other benefits, or benefit plan, program, or arrangement is part of an organized health care arrangement of which the Plan also is a part).

(v) Shall report to the Privacy Official any uses or disclosures of PHI inconsistent with the terms of this Appendix 1 of which it becomes aware.

(vi) Shall make PHI available in accordance with an individual's right of access in accordance with the Plan's Privacy Rule policies and procedures.

(vii) Shall make PHI available for amendment and shall incorporate amendments in accordance with the Plan's Privacy Rule policies and procedures of the Plan.

(viii) Shall make information available to provide any required accounting of disclosures of PHI in accordance with the Plan's Privacy Rule policies and procedures.

(ix) Shall make available to the Secretary of Health and Human Services its internal practices, books, and records relating to the use and disclosure of PHI from the Plan for purposes of determining the Plan's compliance with the Privacy Rule.

(x) Shall, if feasible, return to the Plan or destroy any PHI from the Plan that it maintains in any form, and shall retain no copies of the PHI when the PHI is no longer needed for the purpose for which disclosure was originally made. If it is not feasible to return or destroy the PHI, the Plan Sponsor agrees that it shall further limit any uses and disclosures to those purposes that make the return or the destruction of the information not feasible.

(xi) Shall ensure that adequate separation between the Plan Sponsor and the Plan is established.

Section 4 -- PRIVACY OFFICIAL

Section 4.1 Identity of Privacy Official. The Privacy Official shall be the Fairfax County HIPAA Compliance Manager.

Section 4.2 Power and Authority of the Privacy Official. The Privacy Official shall be entitled to delegate its powers and responsibilities in accordance with its usual practices.

Section 4.3 Responsibilities of the Privacy Official. The Privacy Official shall have the duties and responsibilities specified in the law. Such duties and responsibilities shall include accepting and verifying the

accuracy and completeness of any certification provided by the Plan Sponsor with respect to disclosures and uses of PHI, and transmitting the certification to any Health Insurance Issuers or Health Maintenance Organizations with respect to the Plan in order to permit them to disclose information to the Plan Sponsor based on such certification.

Section 5 -- USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Section 5.1 Permitted Uses and Disclosures of PHI

a. Certification. The Plan, and any Health Insurance Issuer or Health Maintenance Organization with respect to the Plan, may disclose PHI to the Plan Sponsor only following receipt by the Plan, and any Health Insurance Issuer or Health Maintenance Organization with respect to the Plan, of the Plan Sponsor's certification that the Plan has been amended in accordance with the requirements of the Privacy Rule.

b. Plan Administration. The following uses and disclosures of PHI by the Plan Sponsor for purposes of plan administration are permitted provided they are consistent with 45 CFR § 164.502(a)(1)(ii) or (iii), and any successors thereto:
   (i) Disclosures necessary to adjudicate appeal of denied claims (including disclosures to any necessary external experts in accordance with the Plan's claims review procedures).
   (ii) Disclosures necessary to provide assistance to participants and beneficiaries in the claims process (*i.e.*, claims advocacy).
   (iii) Disclosures necessary to provide information for purposes of selecting and contracting with service providers to the Plan.

c. Compliance with Privacy Rule. The following uses and disclosures of PHI by the Plan Sponsor for purposes of complying with the Privacy Rule are permitted to the extent necessary for compliance.
   (i) Uses and disclosures required under 45 CFR § 164.502(a)(2)(i) and (ii), or any successors thereto.
   (ii) Uses and disclosures permitted without permission from an individual under the following provisions of the Privacy Rule, or any successors thereto:
      (A) 45 CFR § 164.502(a)(i) (to the individual);
      (B) 45 CFR § 164.512 (specified uses and disclosures);
      (C) 45 CFR § 164.504(e) (disclosures to Business Associates);
      (D) 45 CFR § 164.502(a)(i)(iii) (incidental disclosures).
   (iii) Uses and disclosures permitted only with explicit or implicit authorization under 45 CFR § 164.508 or 45 CFR § 164.510, or any successors thereto.
   (iv) Uses and disclosures permitted because the PHI has been cleansed. Under the following provisions of the Privacy Rule, or any successors thereto:
      (A) 45 CFR § 164.514(b) (de-identified information);
      (B) 45 CFR § 164.514(e) (limited data sets).

d. Participation and Enrollment Information. Participation and Enrollment Information may be disclosed as necessary to the Plan Sponsor.

e. Summary Health Information. Summary Health Information may be disclosed to the Plan Sponsor for the limited purpose of performing Settlor Functions.

f. De-Identified Information. De-Identified Information is not subject to the Privacy Rule and may be disclosed to the Plan Sponsor at any time.

Section 5.2 -- Individuals With Access to PHI

a. For purposes of the Privacy Rule, the following individuals or groups of individuals are under the direct control of the Plan Sponsor will be treated as the workforce of the Plan Sponsor, and are permitted to have access to PHI disclosed by the Plan or any Health Insurance Issuer or Health Maintenance Organization for the purposes specified.

(i) Staff of the Employee Benefits Division of the Department of Human Resources for all purposes relating to the administration of the Plan.

(ii) Members of the Payroll Division of the Department of Human Resources for premium payment responsibilities.

(iii) Members of the Employee Relations Division of the Department of Human Resources for all purposes relating to the administration of the Employee Assistance Program.

b. Any characterization of an individual as being under the direct control of the Plan Sponsor is exclusively for the purpose of the Privacy Rule and has no other significance. Such characterization for purposes of the Privacy Rule does not, for example, create any employment relationship or result in any entitlement to benefits under this Plan or any other benefit plan, scheme, or arrangement of the Company.

c. The Privacy Official and his or her delegates, if any, are permitted to have access to PHI disclosed by the Plan and any Health Insurance Issuer or Health Maintenance Organization with respect to the Plan.

Section 5.3 -- Limitations on Disclosures of, Access to, and Uses of PHI. PHI may be disclosed from the Plan only for Plan Administration Functions performed on behalf of the Plan, and the other purposes listed in Section 5.1, above. Any employees or other persons listed in Section 5.2 hereof shall have access to PHI only to perform Plan Administration Functions, and other functions listed in Section 5.1, above, on behalf of the Plan.

Section 6 -- NONCOMPLIANCE WITH ESTABLISHED LIMITATIONS ON ACCESS, DISCLOSURE, AND USE OF PHI

Section 6.1 Noncompliance. If the Plan Sponsor becomes aware of the fact that an employee or other individual listed in Section 5.2 hereof has failed to comply with the access or use limitations on PHI described in Section 5.1 hereof, the Plan Sponsor shall inform the Privacy Official and the Privacy Official shall determine in accordance with the Plan's Privacy Rule policies and procedures, what sanctions, if any, should be imposed.

DEADLINE CALENDAR: Jan.-Mar.

DEADLINE CALENDAR: Apr.-June

DEADLINE CALENDAR: Jul.-Sept.

DEADLINE CALENDAR: Oct.-Dec.

WHO'S WHO IN BENEFITS

Supervisor
Karen Diviney 324-4917

Benefits Team Leaders
Sharon Boelcskevy 324-3432
Mary Hoffman 324-4915

COBRA
(Continuation of health insurance upon termination of coverage)

Doug Sachs 324-3316

Deferred Compensation

- **ICMA**
  Paul Brown 324-4916
- **T. Rowe Price**
  Paul Brown 324-4916
- **VALIC**
  Paul Brown 324-4916
- **HELP Desk** 324-4995
  Mitch Falter, VALIC
  Craig Brown, ICMA

Dental Insurance

- **Dental Benefit Providers**
  324-4708
- **Dominion Dental Services**
  324-3318

Family /Medical Leave Benefits
Paul Brown 324-4916

Virginia College Savings Plan
- **HELP Desk** 324-4995

Flexible Spending Accounts
Dependent Care Assistance/
Medical Spending Accounts
Paul Brown 324-4916

Health Insurance
- **FairChoice+/ BlueChoice Blue Preferred PPO**
 324-3318
- **HELP Desk- for CareFirst plans**
  Betsy Fuhrman 324-3474
- **CIGNA**
  324-4708
- **Kaiser**
 324-4708

Leave Without Pay Benefits
Paul Brown 324-4916

Long Term Care Insurance
Mary Hoffman. 324-4915
Paul Brown 324-4916
Tram Nguyen 324-3437

Long Term Disability Insurance (LTD)
Tram Nguyen 324-3437

Life Insurance
- Group Term Life Insurance
  Donna Dowd 324-3374
  Tram Nguyen 324-3437

- Universal Life Insurance
  Donna Dowd 324-3374
  Tram Nguyen 324-3437